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NEUROLOGICAL INSTITUTE OF NEW YORK

Symposium on Alcoholism, page 32

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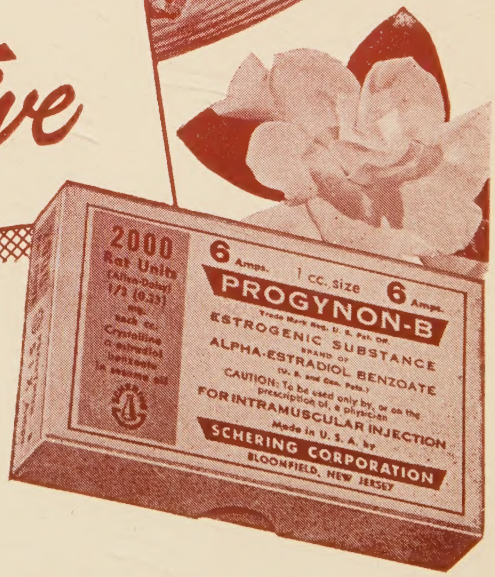
Vol. 158, No. 1

Without Fear *at Forty-Five*



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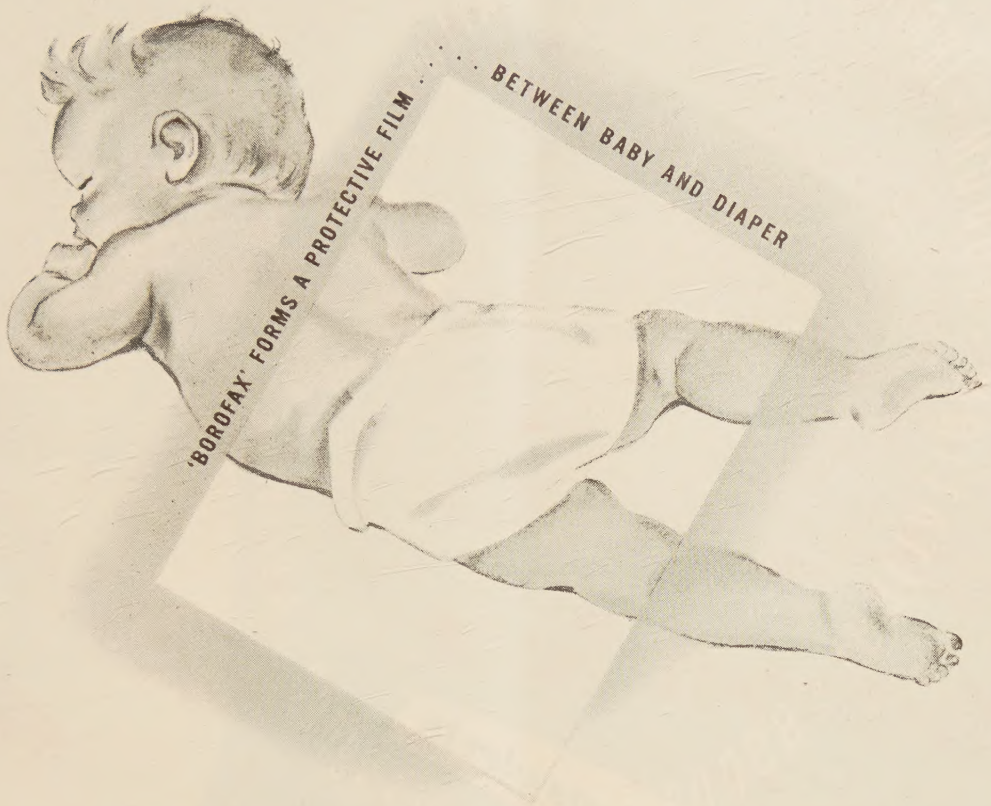

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Graphology in Medicine

Wladimir Eliasberg (*Jour. Nerv. and Ment. Dis.*, October 1944) reviews the subject of graphology and its development into a science. He analyzes the various stages of this development and points out the value of graphology to the physician in the diagnosis and prognosis of disease.

The author says that in graphology there are two developments, one of which dates back to antiquity, which is graphology in the narrower sense, meaning a knowledge of character based on handwriting. The differentiation between graphology and knowledge of handwriting is as impossible, he points out, as would be a diagnostic method in medicine which excluded pathophysiological pictures. True graphology, he says, rests on the fact that there is a psychophysical correspondence and particularly a motor and spatial symbolism corresponding to the emotions and character traits. Both character graphology and the knowledge of handwriting are indebted to medical pathology. Graphology, like psychology, while keeping abreast of the developments in neighboring sciences, among them neurology, is, however, an independent science and must be developed as such, not as a handmaiden of neurology but as an equal partner. The most valuable contribution of neurology and physiology to graphology consists in the clarifications of the physiological process of writing. To social psychology, graphology is indebted for observations on the influence of social psychological factors on handwriting. Future developments will have to show to what degree sociological, psychological and pathological factors may influence the individual handwriting. At present, it may be said that the socalled emotional psychoses may cause sociological factors to disappear while they may combine in handwriting and in the mind with various psychological factors. Future experimental work will have to compare our present graphological convictions with the graphs gained through one of the modern methods of expressive psychology. Laymen cannot diagnose diseases. They should not do it under the guise of graphology either.

While the diagnostic field must be reserved for the physician who should be acquainted with the valuable contributions of graphology, among other diagnostic methods, the graphologist should have knowledge about pathological marks in handwriting. Medicine may use graphology for the diagnosis of disease entities and differential diagnosis; for the prognosis of the development of the disease and for the prognosis based on the character of the patients; for better knowledge of the subjective factors, among them the adjustments of the patient to his disease; for records showing the course of the disease and the effect of treatment; for better use of the psychological factors in treatment; for special applications, such as psychological evaluation in the prognosis of life insurance prospects, and the evalution of the subjective and the physiological age of the writer as compared with his chronological age.

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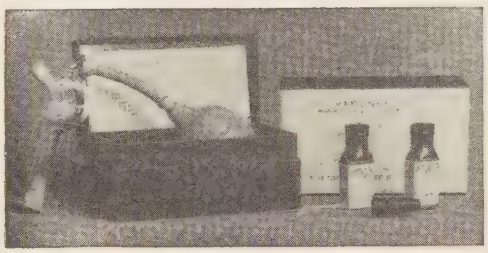

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Open Forum

Silver Star Awarded to Dr. Ralph Schwartz

The Silver Star has been awarded to Dr. Ralph Schwartz, formerly of Brooklyn, N.Y., captain in the Medical Corps of the Forty-eighth Armored Medical Battalion, for gallantry in action in Normandy, France. The citation reads as follows:

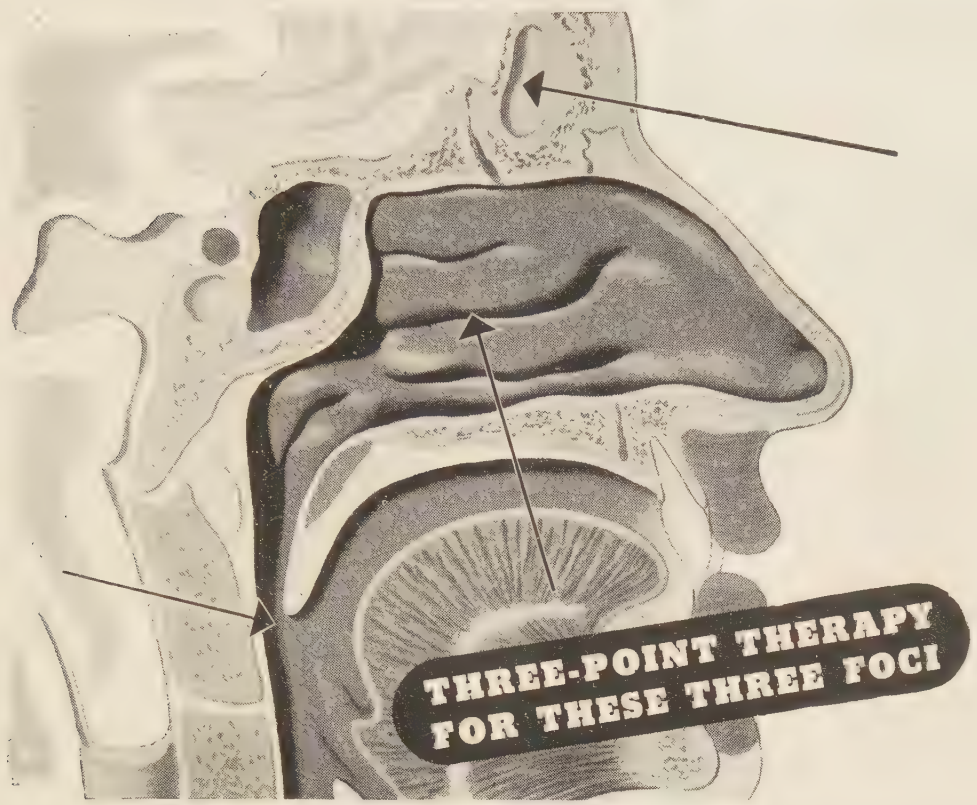
"Captain Schwartz with a group of enlisted personnel was rendering medical service on the 29th of July 1944 in a surgical tent located one-half mile north of Notre Dame La Cenilly, France, to two United States Army patients and three enemy (German) patients when at 2220 hours of this date a terrific anti-aircraft barrage opened up on a group of enemy planes which were over the area. Captain Schwartz advised his group to place patients under cover and then to find cover for themselves when a cluster of anti-personnel bombs struck immediate vicinity scattering shrapnel all through the surgical tent causing many casualties and also many clusters of anti-personnel bombs struck surrounding areas, causing about thirty-five (35) casualties in all. As soon as the first attack subsided, Captain Schwartz, who was not injured, organized the uninjured portion of his group and remainder of the uninjured personnel of this medical section into an active working team of First Aid men, Litter Bearers and Ambulance drivers. Captain Schwartz continued working and leading this team through two additional enemy air-raids without regard for his personal safety in order that all the wounded might be gathered up and treated and immediately evacuated. He held his men together by words of encouragement and the fact that he did most of the work himself, greatly strengthened the moral and working efficiency of his group. Rapid first aid and evacuation of these casualties under such difficult circumstances could not have been accomplished without Captain Schwartz's gallant leadership and superb supervision."

The March of Dimes

Forty-three prominent industrial and civic leaders have been appointed as state chairmen for the March of Dimes and will direct the fund-raising appeal of The National Foundation for Infantile Paralysis, January 14th to 31st, in their states.

Although the infantile paralysis epidemic of 1944, with nearly nineteen thousand cases already reported, was the second largest in the recorded history of the disease in the United States, the nation was better prepared to meet the situation. Epidemic areas included North Carolina, New York, Kentucky, Ohio, Virginia, Pennsylvania and Michigan; Tennessee, Maryland, Indiana, Louisiana, New Jersey, Mississippi, Connecticut and the District of Columbia were also severely affected.

Funds raised through the 1945 March of Dimes, January 14-31, will be used to provide continued treatment for 1944 victims of poliomyelitis and victims of previous years. They will also serve as a bulwark of defense against any 1945 invasion of this home-front enemy. Fifty percent of each contribution is retained in the county where it was provided; the other fifty percent will be used to further the National Foundation's program of research, epidemic aid and education.



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Studies in Medical Sociology

The results of a series of studies made for the purpose of showing the relation of mental disorders to the community socioeconomic level to population density and to race and nationality are presented in *The New England Journal of Medicine,* October 19th, 26th, and November 2, 1944.

The first two of these studies, which dealt with the relation of mental disorders to community socioeconomic level and population density, were made by Major Robert W. Hyde and Sergeant Lowell V. Kingsley, A.U.S. The rejection rates of psychiatric rejections in sixty thousand selectees examined at the Boston Armed Forces Induction Station which were determined and classified according to the socioeconomic level of the community from which the selectees came. An attempt was made to show the relation of mental disorders to socioeconomic factors.

They found that the total incidence of major mental disorders increased gradually from 7.3 percent in the best communities to 16.6 percent in the poorest communities, and that there was a steplike increase in the rate of mental deficiency as the socioeconomic level of the community declined, from 0.9 percent in the best communities to 3.0 percent in the poorest. The rate of psychopathic personality increased from 2.4 percent in the best communities to 6.9 percent in the poorest. In spite of the wide difference at the extremes there was little variation among communities of intermediate desirability levels. The rate for chronic alcoholism did not vary significantly in the better half of the communities and increased only in the poorest and densest communities, suggesting that socioeconomic level *per se* is secondary in importance to density of population in determining the incidence of chronic alcoholism. The rate for psychoneurosis showed no consistent variation with socioeconomic level; there was no increase in the poorer communities, whereas throughout the communities of intermediate desirability there was a slight increase. The rate of psychoses increased with declining socioeconomic level, and variation from the average was most marked at the two extremes of desirability.

These findings were explained on the basis of gravitation of the more unfit into the poorer communities and of differences in cultural acceptability of asocial conduct at different socioeconomic levels.

The rejection rates for the major mental disorders found in this group of selectees were compared with the population densities of the communities from which the selectees came, with the following findings.

Mental disorders differ in type in areas of different population density, irrespective of factors of socioeconomic level and national origin. The highest rate of disorders are at the two extremes, with the highest rate of mental deficiency and psychoneurosis in the semirural areas and the lowest in the small cities. The highest rate of chronic alcoholism and of psychopathic personality is in a large city (Boston); the lowest rate for chronic alcoholism in the semirural communities, and the lowest for psychopathic personalities in the small cities. Only chronic alcoholism is correlated with population density throughout its complete range. It appears more closely associated with density than with socioeconomic level.

This study points to the need of intensive study in

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(1) West. J. Surg., Obst. & Gyn., 51:150, 1943; (2) Clin. Med. & Surg., 46:327, 1939; (3) Am. J. Obst. & Gyn., 46:259, 1943.

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communities of different population density regarding the influence of the community environment on mental health.

The third in this series of studies in medical sociology was conducted by Major Robert W. Hyde in collaboration with Staff Sergeant Robert M. Chisholm, in an effort to determine the relation of the mental disorders to race and nationality. The study was based on the rejection rates for five types of mental disorders among seven different national or racial groups.

In an effort to determine the relation of mental disorders to race and nationality Major Hyde and Sergeant Chisholm determined the rejection rates for five types of mental disorders among seven different national or racial groups. Their findings may be summarized as follows:

The Negroes, Irish and Italians have high rates for psychopathic personality and chronic alcoholism; the Negroes, Chinese, Russian Jews and Portuguese for psychoneurosis; and the Chinese, Negroes, Italians and Portuguese for mental deficiency. The Negroes have high rates for all five types of disorder. The old Americans have comparatively low rates. These findings are partly explained in terms of socioeconomic level, population density and the cultural differences of the different nationalities.

The authors conclude that this study presents sufficient evidence of cultural differences as etiological factors in mental disorders to suggest both the need of further investigation in this direction and the possibility of extensive application of mental hygiene.

New Quarantine Measures

A quarantine branch in the epidemiology division, Preventive Medicine Service, Office of the Surgeon General, has been established under the direction of Lieutenant Colonel Phillip T. Knies, Army quarantine liaison officer. Close cooperation will be maintained with the Public Health Service, the Navy, and other government agencies concerned with quarantine. The new program, which aims to extend precautionary measures throughout the Army's far-flung routes of travel, is part of the Medical Department's continuing battle against disease. In the past, quarantine has depended mainly upon examination of passengers and cargo on arrival, but the new Army quarantine policy takes advantage of the Army immunization program, the constant medical supervision of the soldier, and new methods for the control of insects and rodents. In addition, the Army will continue to cooperate with civil agencies in the enforcement of existing restrictions against the importation of many plants, animals and curios which might harbor diseases or pests. Future developments in the field of quarantine, according to the report submitted by the Inter-department Quarantine Commission, will feature greatly improved methods for the international notification of disease, along with improved health certification of travelers.

Dr. Fuller Albright, Harvard Medical School, Boston, received one of the Mead Johnson Awards presented through the American Academy of Pediatrics at its meeting in St. Louis, Mo., in November, in recognition of his studies on the skeletal and metabolic disturbances in hyperparathyroidism, hypoparathyroidism, rickets and other diseases affecting bone formation and the processes of calcification.

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Rehabilitation of Blinded War Veterans

The most important factor in the rehabilitation of newly blinded war veterans is helping them gain a sense of naturalness, according to Lieutenant Carolyn Jones, officer in charge of the work room for the blind at Valley Forge General Hospital, Phoenixville, Pa. Speaking at a conference of WAC officers in Baltimore recently, Lieutenant Jones said that the first few weeks at the hospital are the most important in teaching the men how to talk, walk and work naturally because it is during this time that they must overcome the fear of darkness which is their worst struggle in regaining a place in the normal world.

Newly admitted patients at Valley Forge General Hospital, which is the eye treatment center for all casualties returned from the European and North African theaters, at first are accompanied through the hospital and adjoining grounds by a personal guide, who helps them to walk "positively and courageously" without stumbling or shuffling.

"After learning to walk, the newly blinded patients enter into a planned daily routine which includes arts and crafts in the work room. Here the patients learn to make leather belts, beaded bracelets and pottery. In every aspect of their life at the hospital the newly blinded patients are encouraged to act naturally. They use the verbs 'see' and 'look' and many are particular about the color and design of the work they produce. Often special shades of wool and paints must be ordered to meet the demands of the workers, who are urged to take an interest in the final appearance of their work."

One veteran, Lieutenant Jones said, always insisted that a mirror be placed before him when he shaved. Attendants at the hospital are anxious to comply with any wishes of this type since they encourage the patients to feel that their life is normal. Dancing classes have been instituted to help the men regain their sense of balance and roller skating instruction may be started at a later date. All these activities are designed to help the newly blinded men recover his confidence and feeling of naturalness.

Lieutenant Jones has been engaged in occupational therapy since 1918 and has been at Valley Forge Hospital for nearly a year as rehabilitation instructor to the blind.

Neuropsychiatric Casualties

Colonel W. C. Menninger, M.C., chief consultant in Neuropsychiatry, Office of the Surgeon General, discussed the problem of the discharged neuropsychiatric patient at the annual meeting of the Association for Research in Nervous and Mental Diseases, held in New York, December 15, 1944. Declaring that the problem facing the individual and communities is unquestionably of great magnitude, Colonel Menninger said that "the statisticians' figures of the number of such men is prone to be interpreted as indicating a much more alarming state of affairs than actually exists". He pointed out that neuropsychiatric casualties of the last war were extremely expensive, in manpower and money. He asked the cooperation of the association in debunking misconceptions about the neuropsychiatric patient and educating the public concerning the problems involved. He emphasized the responsibility of physicians, particularly psychiatrists, in helping returned soldiers, with a neuropsychiatric diagnosis, readjust to civilian life.

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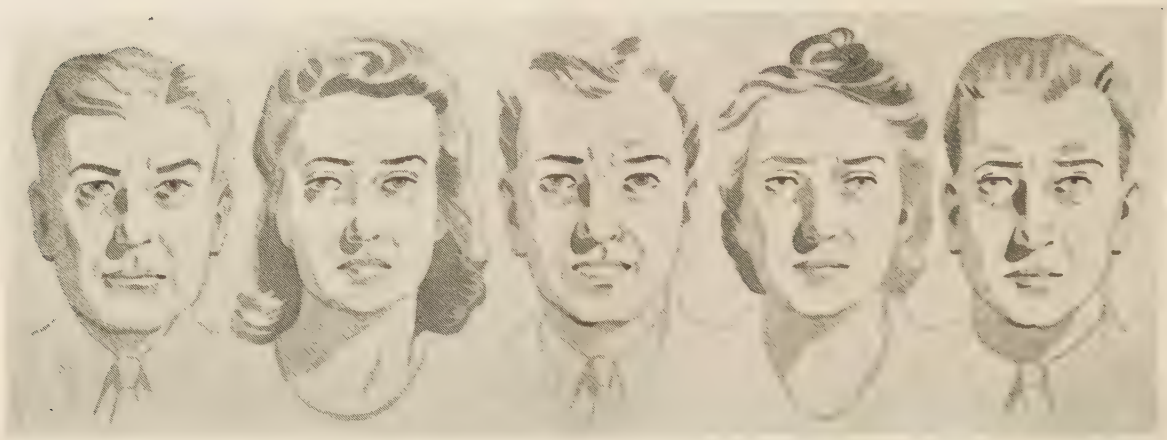

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Of the chronic diseases prevalent in industrial communities, the cardiovascular-renal group has been reported to be the most seriously disabling.[1] This is particularly significant at present, since a greater productive responsibility is being assumed by the more advanced in age. The high incidence of this group of chronic diseases among women of the ages 20-34 is also important in this connection.[2]

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1. J.A.M.A., 108:1876, May 29, 1937.
2. Public Health Reports, 56:2071, Oct. 24, 1941.

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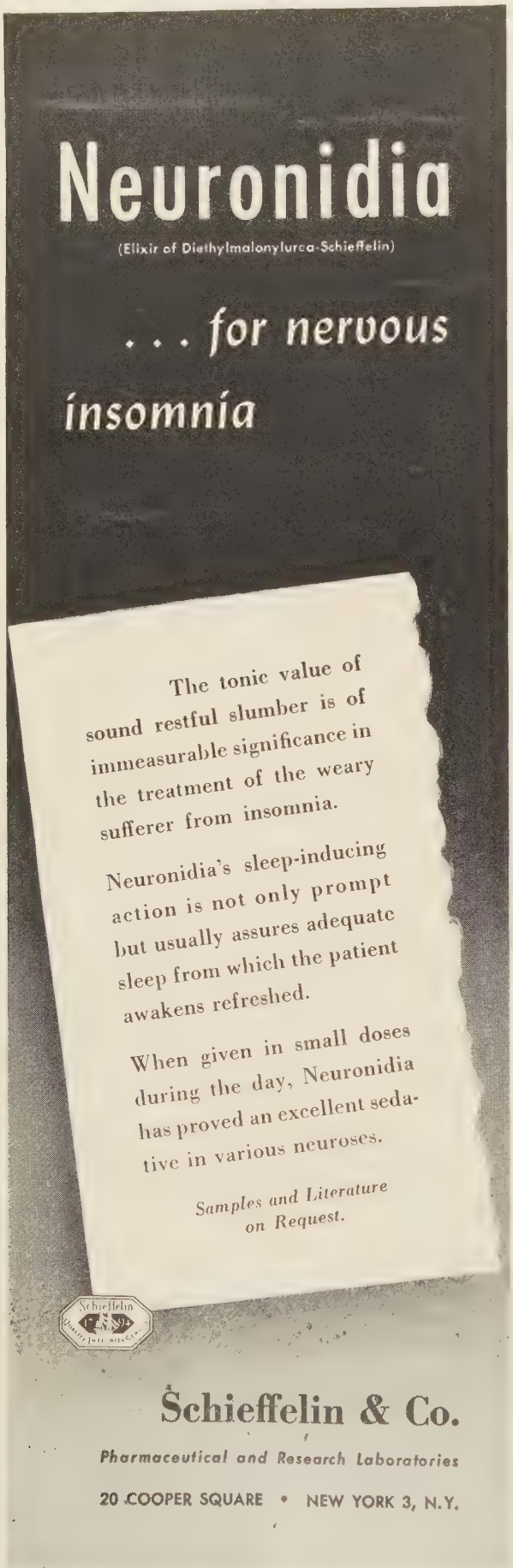
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TRUTH OF THE MATTER

Another Mighty Germ Killer

T. SWANN HARDING
Falls Church, Va.

(*Continued from page 756, December* 1944)

Fermentation covers the entire range of work on the activities of microorganisms, and is not solely concerned with producing alcoholic beverages by the use of yeast! The rotting of a fence post is a process of fermentation, in this case carried on by soil organisms. So is the production of vinegar, acetic acid, citric acid, gluconic acid, and many other powerful and extremely useful substances.

The first step in establishing such a mold laboratory is a large collection of organisms. The laboratory at Peoria has in captivity at least nineteen hundred molds, one thousand yeasts, and five hundred varieties of bacteria. They are kept in test tubes or flasks, or on agar plates, and their whims are carefully considered. For all organisms have a whim of iron, like the weak woman the man married in the storybook. Some of them have to live in refrigerators and others in artificially heated incubators. Now we are back to Prof. Florey of Oxford.

When he arrived in the United States with his assistant he came to urge that methods be devised of producing penicillin on a large scale. He first held conferences with the Committee on Medical Research of the Office of Scientific Research and Development, the National Research Council, and staff members of the Northern Regional Research Laboratory at Peoria. Wasn't it the most natural thing in the world that large-scale methods of producing penicillin by the activity of a mold should be referred to the laboratory which possessed the microbe zoo?

Just that happened. The initial work was done there. Because of their experience in handling molds, the staff of this laboratory was able to increase the yield of penicillin a hundred-fold. Thereupon the drug became of interest to industry, and it is now being studied by thirty to forty producers of drugs and chemicals, under the supervision of the Committee on Medical Research in the Office of Scientific Research and Development, of which Dr. A. N. Richards is chairman.

While a great deal of industrial work is going on, possible improvements in the production method are being sought in the Northern Regional Research Laboratory. Efforts are also being made to uncover the drug's last secret, that of its architectural or structural formula. Once that is learned, it may be possible to synthesize the chemical by other means, just as some vitamins are now built up artificially and without the laborious necessity for extracting them from natural sources.

Penicillin has meanwhile been found most effective in treating osteomyelitis, staphylococcus and streptococcus infections, meningitis, pneumonia, gas gangrene, and other ills caused by organisms of a certain type. At present all supplies of this material being produced are reserved for clinical testing. Do not go down and ask your corner druggist for any. Even if he had it, he couldn't sell it to you.

Clinical tests of the drug are being carried on under the direction of Dr. Chester Keefer, Evans Memorial

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Hospital, in Boston. Instances of remarkable cures are already appearing in the press and the medical journals. Some concern soldiers brought from the South Pacific battle areas with shattered, infected bones, and open wounds that had been draining for half a year. Severe cases treated with penicillin have often been cured in two weeks—some even more spectacularly.

Since practically all the penicillin now produced is used by our armed forces, the drug may remain unavailable for ordinary civilians until the end of the war. Certainly this will be true unless production is enormously speeded up, which is always possible. Little is known about its specific action or, as we have seen, its composition, hence the treatment is so far empirical. However, no toxic after-effects have been observed so far.

The mold laboratory, of course, works on many other valuable projects and produces many other results of industrial and peacetime importance. Each microbe it has requires individual study, though the one that grows on shoes in a damp closet seems to have limited possibilities at the moment! There are also sulky and balky microbe strains that it is difficult for the keepers to train to any useful activity. On the other hand, Aspergillus niger, a relative of the mold that ruins bread, can be taught to eat sugar-beet pulp, artichokes, molasses, potatoes, or corn sugar, and to turn out tremendous quantities of citric acid in the process.

It was a confirmed pipe smoker, Dr. Andrew Moyer, who took Penicillium notatum in hand at the Northern Regional Research Laboratory. He thought perhaps the British were not feeding it properly to bring out its more engaging characteristics. He wondered if it might not grow on corn-steep liquor, the water that starch makers use to soak corn in, thereafter a waste product. That idea worked, production shot up, and then better foods still were sought. The search still goes on.

Accidents happen here too. The research men at Peoria wanted a microbe that would ferment starch into butylene glycol, a step on the route to a good rubber substitute, and also a fair substitute for glycerine itself. No microbe strain present in the laboratory proved up to the job. Then a sample of spoiled starch turned up. The workers found the microbe that had ruined it, and that proved to be the one they were after. Somewhat similarly a bacterium that accidentally contaminated a flask of material in this laboratory turned out to be one which would produce valuable 2-ketogluconic acid, an excellent preservative for salad oil, beer, and ale.

So it goes. Scientists still find out a great deal by accident. But they also discover plenty on purpose, simply by keen observation and painstaking follow-up work. Meanwhile, a thirty-three-year-old patient, dying of blood poisoning at a famous clinic, resists sulfadiazine, maintains a temperature of 104°, and is ravaged by staphylococci. Then he is given penicillin—which cannot be taken orally, but may be injected intravenously or intramuscularly—and in twenty-two hours his blood is free from germs. In two more hours his temperature is only 100°. In six days he is normal. Great is penicillin!

Undoubtedly we have here a wartime development that will survive to aid civilians when peace returns. The discovery and therapeutic use of penicillin is the most important achievement medicine has made since the discovery of the sulfa drugs, which the new drug supplements. Because an English scientist made an accidental observation, and knew how to benefit from it; because two other English scientists determined to put this discovery to work; and because there was a fine microbe collection, along with still other trained scientists, at the Northern Regional Research Laboratory at Peoria, Ill., penicillin became a useful adjunct to medical therapy.

Granite Gables

A Story About Sir William Osler

To the Editor:—

I was a student of medicine when I was offered the chair of mathematics in the Government Normal School in Ottawa. This chair being abolished, I took to law, but never have lost my love of medicine. I have always admired Dr. William Osler, and he offered me an Honorary M.D. of Oxford University, when he was a professor there. This I declined—to my lasting sorrow. One story that is told of him, I have investigated, and can safely certify as true; it will interest all medical men.

At a meeting of the Medical Association of Ontario, Dr. Osler, then a professor of medicine in an American university, attended, as did his old preceptor, well-known and much esteemed throughout Canada.

The operation for appendicitis was then a recent practice, and, naturally, a paper was read on the subject. In this it was set out explicitly that the operation was practically safe when the patient was an infant. The elderly doctor heard the paper with great interest, and moving a vote of thanks, suggested that it might be of great advantage to operate on every infant shortly after birth, and he said: "Such an operation becoming universal, it is probable that in time children would all be born without an appendix, which is as useless as it is dangerous."

Dr. Osler, speaking later, said that he could not think that such a practice would have such an effect. A similar practice had been in universal use with a prominent people, but it was found that the young Hebrew continued to be born with a prepuce as surely as the young Gentile.

William Renwick Riddell
Toronto, Canada

Reduction in the Army Medical Corps

A moderate reduction in numbers of Army Medical Corps officers is necessary in order to remain within presently allotted ceilings, the Office of the Surgeon General has announced. The need for Medical Corps officers in senior grades who are assigned principally to administrative duties is less acute than formerly.

A board of officers recently appointed in the Office of the Surgeon General is carefully considering the physical and other qualifications of all medical corps officers of the various components of the Army and their essentiality to the war effort. As a result of this board's study, it is anticipated that a number of separations of the above named group will occur in the moderately near future. Regular Medical Corps officers will be accorded retirement privileges under the provisions of Section II, Ar. 605-245, June 17, 1941, and Reserve, National Guard, and A.U.S. Medical Corps officers will be given the opportunity of returning to the practice of medicine in a civilian status by relief from active duty or discharge.

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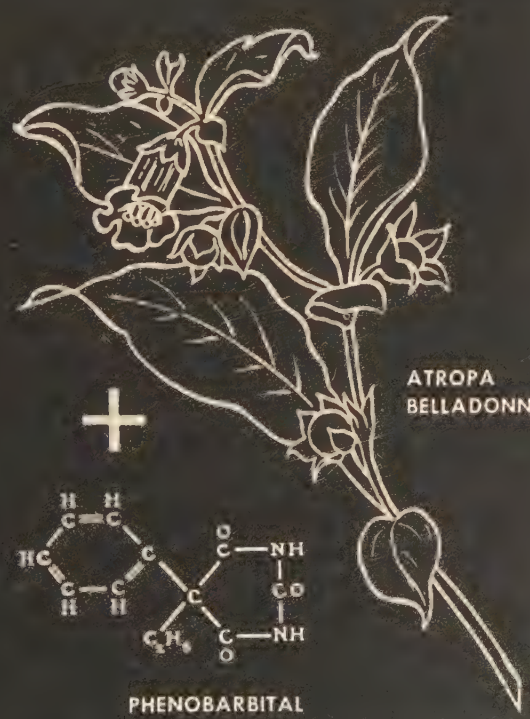

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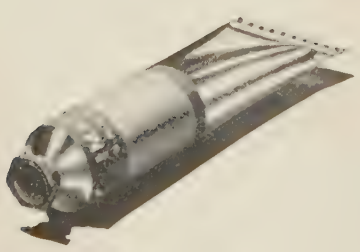

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VOL. 158, No. 1 JANUARY 1945 WHOLE No. 2744

GENIUS AND DISEASE

F. E. CHIDESTER, A.M., Ph.D.
Newark, New Jersey

Is genius only a step from insanity, or is it "two thirds perspiration and one third inspiration?" Is genius a result of tuberculosis or gout, or the dread syphilis, or is it merely a sign of unrequited love?

Much has been written about the remarkable achievements of sickly and handicapped persons. The great Molière had weak lungs; Ibsen, and our own Nobel prizewinner, Minot, are known to have been diabetic; Handel suffered from paralysis; Charles Darwin had gout and was able to work only a short time before resting; Stevenson burned with the fire of tuberculosis. As George Jean Nathan has said, "Art is the child of ill health." This certainly was the case with Michelangelo, who had a violent intestinal disorder.

Many talented persons might have lived and died unknown, if the disease which caused them to achieve so much had not set up tremendous activity in their protective mechanisms. Along with the disease itself, in many such cases, had gone the feeling that life was short, and that every moment must be used. They said to themselves, "I must and *will* be heard, for death will soon come."

The chemistry of disease involves an overactive set of glands of internal secretion, pouring iodine into the body fluids. We know that iodine speeds up thought processes. It does this by breaking down fat-like constituents in the brain, and enabling the rapid passage of nerve impulses. This, I have long believed to involve the combustion of iodine and phosphorized fats. The famous surgeon and authority on glands, Dr. George Crile, said, "In a sense, Phi Beta Kappa itself is a disease." He has linked thyroid overactivity with the mental drive that brings high scholastic honors.

Let us make no mistake, however, in assuming that genius requires the existence of some disease which activates the glandular mechanisms. For many persons without thyroid hyperactivity, due to dietary deficiency, or to some infection, have by *sheer will power,* and emotional control, been able to achieve amazing results, truly the marks of genius.

Emotional disturbance has been reported to increase the blood iodine from twenty percent to fifty percent in thirteen of fifteen subjects reported to the Royal Society of Medicine in London, in July, 1937.

A few years ago, when Cannon's theory of the relationship between the adrenal glands, rage, fear and the speeding up of physical and mental processes was first published, I was amused and delighted to witness two of my students, in a terrific argument, just before a quiz. Finally they burst out laughing, and said, "We were pitching into each other to stimulate our adrenals, so that we could pass your examination".

I have been able to show how the adrenal effects are really attributable to iodine in the blood liberated from the thyroid, adrenals and other glands, and that *iodine* is the key element in all the endocrine glands (1). In Salter's new book on *Iodine and Endocrine Balance* (2), much evidence is given clinically to support this idea.

The indomitable will steps in, controlling glandular activity, to determine a procedure that may set the whole world ahead, or it may push civilization back for a hundred years, depending on the conditions that shaped the character of the leader.

As Dorothea Brandé has shown in her book, *Wake Up and Live,* it is possible by exercising the will, to overcome the lethargic condition that may be due in part to overeating, and lack of exercise. A determined effort will bring the lazy thyroid into line. We may suggest at this point that a proper diet will help in strengthening the *will,* and that a reduced fat intake will burden the glands less.

Gout has been called the "disease of genius". In an analysis of the distinguished, Havelock Ellis found that gout occurs five times as often among the British men of genius as in the rest of the population. In 1661, Jesuit Father Balde published a book on gout, which he called "the leader of diseases and disease of leaders".

There is a close connection between the thyroid, the pituitary gland, the adrenals, and the occurrence of a gouty condition. Lindemann found that all of his cases of irregular gout showed signs of disturbance of the glands of internal secretion, and especially of the thyroid. Certain foods (purins, including meats and caffeine) produce a thyroid hypertrophy like that in toxic goiter. The fact that a diet rich in purins stimulates the nervous system through the thyroid gland has been well demonstrated. "After three months of vegetarianism, I was obliged to destroy everything I wrote during that period, because of a lack of meat", is the confession of Herbert Spencer. Coffee and tea stimulate the brain indirectly, by activing the thyroid, and many a "genius" finds them almost indispensable.

Syphilis and Genius

Because some celebrated men have become insane, there has been a tendency to overlook the nature of the disease that first increased their mental activity, but finally destroyed the brain itself. This is especially true in the case of syphilis, which is responsible for some very erratic geniuses.

Napoleon is known to have suffered from "the hereditary curse of his family", a cancerous stomach. But he was also treated with mercury for syphilis, and historians believe that his wild dream of power was an instance of syphilitic megalomania. The present world menace is reported to have cancer of the throat and to be eunuchoid, hysterical, and glandularly unbalanced. What a conqueror!

Beethoven, who composed his ninth symphony after he had become so deaf that he could not hear a note, showed syphilitic tendencies in his early twenties. It is known that he was treated for syphilis over a period of years. Deafness with syphilis appeared also in the case of the Bohemian composer, Smetana.

Eugene Sue, the celebrated French novelist, was a surgeon, then a painter, and finally, after acquiring syphilis, become a writer. DeMaupassant acquired syphilis when he was twenty-seven years of age. During the next ten years he wrote six novels, two hundred and fifteen novelettes, and two dramas. He wrote to a relative, a few months before his death, "Never before in all my life has it been as easy for me to create as it is just now".

The painter, Van Gogh, whose work has been exhibited in large art museums for several years, was twenty-seven years of age before he began using the brush. He died ten years later, from syphilis. As death drew nearer, his activity became feverish. His paintings suggest the insanity that caused him to spend a number of years in an asylum, after he had cut off one of his ears. Gauguin, another *modernist* in painting, also showed in his pictures the development of the syphilis that has helped in the rise of a "new school of painting", transitory in popularity, we hope.

Von Behring, the founder of the science of immunology, acquired syphilis at an early age and burned out rapidly, but not until he had been awarded the Nobel prize for medical research.

Nietzsche, the German, whose philosophy of the "superman' has so eagerly been adopted by the supporters of Kaiser Wilhelm and Adolph Hitler, acquired syphilis in his twenty-fifth year. His greatest books were written during the last years of his life, as the disease spread farther. He said, five years before he died, "Nothing seems difficult to me any longer. Whatever I write, is written in a playful mood".

When syphilitic organisms or tuberculosis bacilli invade the body, the defensive glands pour out their secretions in an attempt to destroy the injurious organisms. Large amounts of iodine pass to the brain, and exceptional mental acuteness results.

Similarly in the case of alcoholics, there is a great stimulation of the iodine reservoirs, and as the pituitary gland and the midbrain release it into the brain, thought processes are speeded up. This is not a normal condition, and soon becomes uncontrollable. Everyone is familiar with the loss in inhibitions shown by drunken people.

In the treatment of syphilis, earlier medication was with mercuric iodide. More recently, hyperpyrexia—or excessive heat—has been induced by electrical machines which cause artificial fever. Observations of the beneficial effects on syphilis, when patients contracted malarial fever, have resulted in the treatment of advanced cases by that method also.

The chemistry of the attack on syphilis has been greatly improved when *thyroid extract* or iodides were added to the high temperature treatments. For *iodine* attacks the fatlike and waxy coverings of the syphilis organism, and of various bacteria transmitting other diseases.

Tuberculosis and Genius

This brings us to a consideration of tuberculosis and genius. One writer has said of tuberculosis patients, "No other disease with equally extensive lesions exalts a victim so much both physically and mentally".

The Portugese Jew, Spinoza, was a philosopher, who was excommunicated by the synagogue, and denounced as a heretic and an atheist by Protestant and Catholic churchmen, yet they gave reluctant tribute to his gentleness and virtue. He lived in an attic room, wore cheap clothes, ate lightly of the poorest food, and died of tuberculosis when he was still a young man. He refused a gift of a thousand dollars, fearing ease might interfere with his work. Later he was offered an annuity, and still refused to become comfortable and secure.

Gamaliel Bradford, an invalid all his life, wrote one hundred and thirteen "writing portraits", two thousand poems, eight novels, a number of plays, and kept a one million four hundred thousand word "journal". He suffered from vertigo and constant nervous fatigue, but managed to set aside one hour a day for piano playing, and two hours a day for his writing. Bradford's family were tuberculous, also. His mother and all her ten brothers and sisters died from tuberculosis before they were thirty years of age.

In his *Pulmonary Tuberculosis,* Fishberg says: "In tuberculous patients, particularly young talented individuals, enormous intellectual activity of the creative kind is sometimes displayed".

Letulle (3) says: "The tuberculous are in a constant state of nervous irritability, but despite the fact that it hurts their physical condition, they keep active and produce their best work. They astonish everybody with their mental and intellectual activity. Their memory, their quick judgment, their delicate reasoning powers are of incomparable amplitude".

One editor, in a medical journal, whimsically deplored the fact that tuberculosis was being conquered so completely that we would lose the geniuses produced by the disease. He says, "the talent of the next generation, in an era practically free of tuberculosis, will tend to remain just talent. The *lead* of cleverness will not so often be transmuted into the *gold* of genius".

It is not necessary for one to be tuberculous, or diabetic, or to contract some horrible disease like syphilis, in order to come to the full use of his mental powers. Out of the billions of nerve cells in our brains at birth, few of us ever use a fraction of them. The *will* is an agent that can activate glands and cause the body fluids to distribute minerals essential to keen thinking, and control of the mental processes.

Many a cripple, with no wasting disease, but merely a bodily handicap, has shown that the will is master of the mind and the body. As Ralph Waldo Trine has said, "There is no one, if really in earnest, and if he really desires it, who cannot live to his highest for a single hour".

Too many persons cling to their own weaknesses, and refuse to live a fully active and useful life. They fritter away time and energy, doing everything that they can contrive to do, except the thing that is their forte. For everyone has the ability to do *something* better than anyone else in the world.

It has been said that "love is a disease". Alexis Carrel, in his book, *Man the Unknown,* says, "Love stimulates the mind when it does not attain its object". Many a wonderful bit of art, sculpture, painting or literature has come into being because a man loved —in vain.

Today, despite the horrors of war, there are many persons striving to be of service to the world in a really great way, in all branches of science, medicine, and literature. Noble souls in all lands are trying to bring order out of chaos, and to do these things in the spirit of true Christianity.

Pathological geniuses may not injure us much by their crude music, horrible pictures, or ugly sculpture, but in philosophy, literature and, even more, in politics, such a "genius" is a menace, an *evil genius.* Fortunately, good people of the world eventually combine to help a great cause along; and as in the present war, all the forces of right, decency and justice array themselves against brutality, hate and oppression. The pathological genius finds his Saint Helena, when the masses of his own people see his complete selfishness and come into direct contact with his ruthlessness and savagery.

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CHEMOTHERAPY IN TRAUMATIC WOUNDS

*With Report of a Case of Severe Compound Fracture**

LEO F. SCANLON, M.D. and JOSEPH M. GAGLIARDI, M.D.
Philadelphia, Pa.

Since Jaeger's (1) report on the use of a sulfonamide in surgical wounds, the local implantation of sulfonamides has been greeted with great enthusiasm. This enthusiasm is manifested in extensive literature which has appeared in the past several years.

The local implantation of sulfonamides has been used in clean surgical wounds as well as wounds in which infections have been established. Casberg (2) reported that sulfonilamide controlled infection in clean surgical wounds; his treated cases showed no instance of infection, whereas in two control groups infections occurred in 10.5 percent and twelve percent of the cases. In cases where infections had been established, Herrell and Brown (3) employed sulfanilamide with favorable results. Their results seemed equally good regardless of whether the organism isolated was a streptococcus, a staphylococcus or a pneumococcus.

That most compound fractures can be debrided and sutured with satisfactory results if sulfanilamide powder had been implanted in the wound, was amply proved by a series of such cases reported by Jansen et al (4), and by Jackson (5). It was reported by Key et al (6) that the implantation of sulfanilamide powder in a wound did not seriously damage tissue or seriously interfere with wound healing.

In order that the sulfonamide treatment of wounds be successful, it is of extreme importance to use good surgical judgment and sound surgical practice. Lockwood (7) has shown that necrotic material or pus contains sulfonamide inhibitors, hence every effort should be made to eliminate or neutralize these substances before sulfonamide therapy is instituted.

That the incidence of infections could be controlled by the topical application of sulfonamides was our experience, but we did have to contend with some factors which might be considered adverse to the use of sulfonamide powders and crystals. There were times when the sulfonamide powder produced a drying effect in the wound with a tendency toward decreasing its lymphorrhea resulting in an apparent delay in healing. It was also observed that when a sufficient amount of sulfonamide powder or crystals had been instilled into a wound, the effect was that of a foreign body, because of the caking of the powder. Since the use of sulfonamide powder on our service was limited to the treatment and prophylaxis of severe traumatic wounds, these conditions were of frequent rather than occasional occurrence.

Veal and Klepser (8) reported similar experiences in their surgical cases with topical sulfonamide powder, but they solved these difficulties by incorporating allantoin two percent and sulfanilamide ten percent in a nongreasy, water-miscible base[1].

According to Veal and Klepser, this ointment controlled infection through the bacteriostatic action of the sulfanilamide and the allantoin stimulated the formation of health granulations. They concluded: "The substitution of allantoin-sulfanilamide ointment for the pure powder allows a prompt resumption of the normal healing process and at the same time maintains a clean wound".

Allantoin, as a stimulator of tissue growth, particularly in indolent, nonhealing wounds was first investigated by Macalister (9). He used the crude extracts of comfrey root, which on analysis were found to contain allantoin, and also used pure solutions of allantoin to treat chronic ulcers which had failed to respond to all other types of therapy, and became convinced of their efficacy. Brailey (10) reported that allantoin acts as cell proliferant in promoting granulation in corneal ulcers.

*Department of Surgery, St. Agnes Hospital, Philadelphia, Pa.

[1]Allantomide ointment, prepared by The National Drug Co., Philadelphia, Pa.

Continued interest in allantoin as a cell proliferant was stimulated by the report of Robinson (11) who, on investigating the exceptional results of Baer's (12) maggot therapy of wounds, found the active principle to be allantoin which was found in the excretion of maggots. A correlation of facts resulting from his investigation suggested that allantoin might be the active cleansing and stimulating principle.

Kaplan (13) reported that the chief value of allantoin is that it stimulates cell proliferation, that is, it encourages and hastens the formation of cells.

Traumatic Wounds

We have treated seventeen cases of severe trauma, in which the destruction of tissue was extensive, with the allantoin-sulfanilamide ointment in a nongreasy water-miscible base. There was also one case of compound fracture of both bones of the left leg, which is considered worthy of a complete report.

In the treatment of traumatic wounds with extensive tissue destruction, shock was of principal concern. When it existed, it was treated in the conventional surgical manner, after which the wound received attention. The wound was first washed with tincture of green soap, then, taking particular care not to damage major nerve or vascular structure, a thorough debridement was done as early as possible. It was then irrigated with hydrogen peroxide, sponged as dry as possible, and packed with the allantoin-sulfanilamide ointment, covered with vaseline gauze, padded, and a light pressure bandage applied. The dressings were changed on the fifth day, the wound washed with hydrogen peroxide, and if any sloughed tissue was present, this was removed with forceps and knife. No radical debridement was done after the first operation. The allantoin-sulfanilamide ointment was again applied to the wound, and dressed as described above. This procedure was repeated at four day intervals until healing was complete. It was found that allantoin-sulfanilamide cleaned the wound, and controlled infection, with the result that healing progressed uneventfully. Healthy granulations in the deeper structures became evident in the majority of cases at the second change of dressings. It was also observed that marginal epithelization was apparently stimulated by the allantoin-sulfanilamide ointment.

All of the cases treated were studied in regard to blood levels of sulofnilamide, and, from the correlation of facts, there was apparently no relationship between the extent of the area of the wound and the absorption of the drug. None of the patients manifested any toxic reaction to the allantoin-sulfanilamide ointment in the course of treatment. Blood levels up to two mgm. percent were found in a few of the cases, at the start of treatment.

Report of Case of Compound Fracture

The case of the compound fracture of both bones of the leg proved of such interest that we desire to report it in detail.

The patient was a man, aged fifty-one, whose left leg had been crushed on October 4, 1942. He was taken to a local hospital, where a temporary cast was applied. Later the patient noticed a small bluish discoloration on the anterior surface of the foot at approximately the mid-point. The following day, pain was complained of in this area. Forty-eight hours later he noticed an inability to "wiggle his toes". This was followed by anesthesia of the entire foot. The cast was removed on the second day and numerous large blisters were present. At this time debridement was done and the cast reapplied. Subsequent to debridement, an area of ulcerous tissue formed at the site of the discoloration first noticed by the patient, and the family physician informed him that this would have to be drained before the fracture could be healed.

The patient was admitted to our service (December 4, 1942) at St. Agnes Hospital or eight weeks after the original injury. On examination we found an infected compound fracture of both bones at the lower third of the left leg with the distal portions of both tibia and fibula protruding from the wound. The distal fragment of the tibia presented an ivory-like appearance; the proximal portion was spongy. The wound was filled with a foul smelling, yellowish-brown pus. Fascia and tendon sloughs were visible, and the extensive destruction of tissue presented a well-nigh hopeless condition. An opening the size of a fist was seen at the point of fracture. An area of ulceration about the size of a half-dollar was found over the tendo achillis, and also in the popliteal region. The patient was unable to move his toes or foot. There was apparently no other recourse but radical amputation.

Both familial and personal histories were negative. Blood examination showed red cells, 4,300,000; white cells, 11,300; hemoglobin, 84 per cent; polymorphonuclears, 75 percent; lymphcytes, 25 percent; serology (Kahn, Kline and Kolmer), negative.

The x ray findings from an exposure taken on admission to our service presented the following: "The fragment of the tiba shows overlapping with outward displacement of the distal fragment. There is little or no evidence of union, with what appears to be an osteomyelitis involving principally the lower end of the proximal fragment of the tibia."

The wound was irrigated with hypochlorite solution and 120 grains (8.0 Gms.) sulfanilamide powder were placed in the wound. On December 5th, the day after admission, dead muscle and fascia were removed from the lateral aspect of the limb, from which a great deal of pus was draining.

On December 9th, in spite of the hopeless outlook, it was decided on surgical intervention and on December 10th, we operated. Multiple free incisions were made, and two counter incisions which extended downward to the plantar surface of the foot. All involved dead tendons, fascia and muscle tissue were removed. The free ends of the fractured tibia were freed of granulation tissue, both ends were approximated and held *in situ* with two aluminum wires, having drilled the bones through and through in two places. Bichloride solution was used to cleanse the wound and 180 grains (12.0 Gm.) of sulfanilamide powder placed in the wound. Five strips of iodoform pack gauze and a few strips of vaseline gauze were placed next to the bones. Three hundred cc. of blood were transfused on December 12th. The postoperative recovery was fair.

On December 15th all the packings were removed and the wound thoroughly cleansed. Sulfanilamide powder was again implanted, and the wound redressed. Though the infectious process was apparently under

control, the wound showed little healing. It was more or less inactive, being pale and dried out in appearance.

At this point it was decided to try the allantoin-sulfanilamide ointment, and on December 18th six ounces (180 Gms.) of the ointment were inserted directly into the wound. A sterile gauze dressing was applied and two sections of cast were fixed with plaster bandage. The ointment was also applied to the areas of abrasion and infection of the surrounding skin as well as the ulcerated infected area on the tendo achillis.

On December 26th it was noticed that a greenish, foul-smelling fluid was discharging into the floor of the wound. This fluid was removed with sterile swabs, and for the first time since the operation there was evidence of numerous islands of granulation tissue in the floor of the wound. Granulation tissue was also found covering most of the wire used for fixations and approximation. Several white colored areas were found on the proximal and distal fragments of the tibia, which, from its appearance, seemed to be newly formed periosteal tissue. In the opinion of one of us (J.M.G.) there was definite evidence of newly formed granulation tissues which appeared entirely healthy.

Finding such favorable conditions present it was decided to continue the allantoin-sulfanilamide ointment therapy. Four ounces (120 Gms.) of the ointment were placed in the wound, and the split cast reapplied. The leg was not disturbed for ten days.

On January 9, 1943, both wires were removed with the exception of a small portion which was left in place, because its removal would in all probability have disturbed new callus formation. It was decided to remove it at a more favorable time.

Dressings were done at stated intervals, using the same technique as described, and on January 31st, fifty-eight days following operation, little drainage appeared. On February 4th, an x ray was taken which gave the following picture: "There has been no extension of the destructive process as compared to the last examination. There is present some erosion of bone about the wire, and there appears to be some periosteal reaction with what looks like formation of callus about the fracture".

February 14th, the wound was again examined and was found to be closing by granulation, redressed as before with allantoin-sulfanilamide ointment and the course of recovery still uneventful.

An x ray picture taken March 4th showed: "Resorption of bone about the fragment of wire still remaining. There appears to be some evidence of callus formation around the fragments, although it is difficult to say whether there is solid union. The appearance, however, is better than on the last examination." The patient was up and around on March 5th. A walking iron was applied to the cast which was fenestrated. March 8th, the leg was examined, and a small piece of exposed sequestered bone was observed. The leg was redressed as previously described.

On March 28th, the patient was provisionally discharged from the hospital and requested to return in two or three weeks for removal of the sequestrum and remaining piece of wire.

It is of interest to note at this time the truly remarkable recovery of this apparently hopeless case as it appeared on admission. On the face of it, remembering the condition of the limb, it should, beyond reasonable doubt, have been amputated, but we were determined at least to try palliative measures for the time being; that we succeeded in saving the limb is unusual; even we, ourselves, admit it. We agree that the allantoin-sulfanilamide ointment therapy certainly played a definite part in this recovery.

The patient was readmitted to the service June 2nd for removal of sequestrum and wire, which was done under local anesthesia. The sequestrum, removed with forceps, measured two and one-half by three-fourths inches; the wire which remained from the original operation was also removed.

An x ray taken June 2nd showed marked decalcification of bones from disuse; however, fragments of both tibia and fibula appeared solidly united by firm callus.

Recovery was uneventful from the second operation and the patient was discharged June 12, 1943. The terminal scar, as it appeared finally, was deep and extended from the level of the tibial tubercle to the proximal head of the fourth metatarsal bone, laterally.

Summary and Conclusion

Seventeen cases of traumatic wounds with extensive tissue destructive were successfully treated with allantoin two percent-sulfanilamide ten percent incorporated in a special nongreasy, water-miscible base.

One case of compound fracture of both bones of left leg was successfully treated, and it is felt the allantoin-sulfanilamide ointment played a rôle in saving the patient's leg.

Infections were controlled and new, healthy granulation tissues as well as marginal epithelization were apparently stimulated by the allantoin-sulfanilamide ointment.

It was found that restricting the frequency of dressings resulted in more rapid healing. Dressings were changed at four day intervals, with the exception of the compound fracture case, in which dressings were changed at ten day intervals.

None of the patients showed any local or systemic toxic reactions. There was no apparent relationship between the extent of the wound and the absorption of the sulfanilamide from the allantoin-sulfanilamide ointment.

It is suggested that the use of allantoin-sulfanilamide ointment, in a nongreasy, water-miscible base as an adjunct to good surgical practice in traumatic wounds with severe tissue damage is a sound and practical procedure.

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1915 GREEN STREET
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INTERESTING CASES

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I wish to state, by way of preamble, that although a community may be small and isolated, as St. Johns, off "the beaten track" in Northern Arizona, the observant practitioner may meet with interesting, even rare cases that will well repay his close study.

In scarcely more than a year of practice in that remote community and in an adjoining village, among the many interesting cases encountered was one in which pulmonary infarcts occurred in a woman, with a chronic cardiac condition, one week after the successful and uneventful delivery of a healthy baby. Unaccountably, and not provoked by digitalis, an auricular fibrillation had set in (a bad dream was blamed), following which a coronary embolus occurred. After the patient rallied from this, pulmonary infarcts took place, first in one lung and then in the other. Did this chain of events develop from closing or thrombosing endometrial veins, or did the cause reside in the heart? Take a case of the recently discovered Rh factor (Landsteiner and Levine). There was an actual case of this kind in a nearby community. A woman, nonluetic, had had *ten* miscarriages. I saw her in the seventh month of pregnancy in an eclamptic attack, from which she began to rally, only to succumb the same night to a foreseen miscarriage with unchecked bleeding, before medical help could arrive. In the midst of a smallpox epidemic a woman had an attack of herpes zoster, the causal relationship being undoubted. Infectious mononucleosis occurred in a pair of siblings, one had a rash that was blamed on the insignificant amount of sulfathiazole given, although the boy had taken the drug previously with impunity.

Many other interesting cases could be cited. I shall present three which are instructive and interesting, and add a little discussion of my own. The cases are given in an abbreviated form and from memory. At the time I saw the patients, I did not consider reporting their cases.

I: Subacute Bacterial Endocarditis

This disease is by no means as rare as is believed. It was curious to find it here and to observe and follow its development and life history. The case I am reporting concerned a young woman, twenty-three years of age, whose previous history was obscure. One practitioner had accidentally discovered a cardiac murmur, the existence of which was denied by a heart specialist. There followed a brief period of hospitalization and treatment for "cardiac asthma" and an allergy to milk. When I first saw the patient she had a typical "cardiac asthma", i.e., a full blooming left and right cardiac failure with all the trappings, including nausea and vomiting, tender large liver and misleading epigastric pain (there was no coronary involvement), venous congestion and an early pulmonary edema to show that the left ventricle was following suit. Digitalis quickly controlled this condition, but sensitiveness developed to even small doses of the drug. A milk extract was found that did not annoy the patient and helped to solve her nutritional problems. I had "my hands full".

After the acute episode, her condition became static for a time, with the development of chronic heart failure, a large liver, more or less ascites, anasarca and edema. The valvular lesion consisted of a mitral regurgitation with left border enlargement. There were indications of a former rheumatic cardiac involvement, though no presystolic murmur was elicited; the lesion was not congenital. Several more attacks of allergic and "cardiac" asthma occurred. Then, possibly due to an upper respiratory involvement, a symptom complex developed that could not be interpreted as being anything but subacute bacterial endocarditis. The spleen began to show enlargement, some trifling petechiae developed under the nails, and a daily temperature, not traceable to any other cause than bacterial invasion from an ulcerated valve, confirmed the diagnosis. There were no significant changes in the murmur, except that the systolic mitral murmur sounded pancardiac; once I thought I heard a presystolic murmur.

Sulfathiazole treatment was pushed, with occasional relief for a few days. Embolism was feared, and a search was made for heparin or dicoumarin, but neither was obtainable, and, of course, obtaining penicillin, that is supposed to save three percent of the cases, was out of the question. One day, following a longer respite and after a sudden change in the weather, a full-blown pulmonary edema was discovered, showing possible embolism in the lungs, and acute heart failure with all its dreary train of symptoms. Digitalis and atropine were given hypodermically. Care was taken to avoid morphine; phenobarbital was given instead, though woefully inadequate. Before oxygen could be brought the girl died, probably from a cerebral clot, the mother telling me of sudden blindness which was undoubtedly caused by a clot in the circle of Willis. Possibly there was also a coronary clot, as there developed a terminal auricular and possibly, too, a ventricular fibrillation.

II: Multiple Sclerosis, Apoplectiform Type

This was a case from a different field, that of neurology. While we see many cases of multiple sclerosis, comparatively speaking, in big metropolitan hospitals in cities with large foreign populations, the general practitioner sees few cases of this disease in the United States and rarely will even a neurologist in a big city see the apoplectiform type. The differential diagnosis of this disease from intracranial hemorrhage and an embolus is sometimes difficult.

In this case the patient (E.R.) was a boy of seventeen, who had come here on a visit to his grandparents. He had "bumped" his forehead when five years old, he said. He was somewhat slow of speech. Diagnosis showed a cardiac murmur, which on examination was found to be systolic mitral. The boy had a brilliant mind, was a voracious reader and ranked first in his studies. He had undergone slight physical exertion about eight hours prior to his cerebral "insult". This seemed unrelated to it. That same evening, while resting, it was noticed that the right side of his body sagged and he had lost the power of speech. On examination it was found that he had sustained a nearly complete right-sided palsy, flaccid in type, both of motion and sensation of that side. All cranial nerves appeared involved, except the optic, and especially marked among these nerves was the right facial and the nerves supplying the tongue which already appeared atrophied on and deviated to the right side. There was complete absence of all reflexes on that side, an absence of all the abdominals, a prominent Babinski and confirmatories, a complete anarthria, aphasia, but no loss of consciousness. The aphasia was examined in detail later. The optic disks were pale, and there was some nystagmus to the right.

Anatomically this lesion could only be localized in the internal capsule, mainly in the first half and the genu; the optic fibres occupying the rear of that formation were evidently free from invasion. The history of halting speech, and something to the effect that the patient sometimes keeled over "from rheumatism" of the ankle, made the suspicion very strong that this was the apoplectic form of multiple sclerosis. A lumbar puncture was performed at the bedside (Ayer apparatus). The pressure was found to be nearly normal, the fluid free from blood, excluding a subarachnoid hemorrhage. The Pandy test showed moderate globulin and normal dextrose; microscopically, a slight increase of lymphocytes was found. All this agreed with the tentative diagnosis first made. An embolus from the mitral valve had to be excluded. The heart, however, was only slightly enlarged to the left. There was tachycardia, but this could be explained from an intercurrent tonsillar inflammation which sometimes precipitates a picture such as this in multiple sclerosis. There were otherwise no signs of any cardiac decompensation. The proof of the diagnosis lay, of course, in the rapid amelioration of all symptoms which was predicted and came to pass promptly. Medication employed was mainly quinine sulfate, five grains, three times a day (Dr. Brickner's suggestion, which seemed effective, in spite of its repudiation by Wechsler and others), amino acetic acid, panvitamins, etc. Improvement was so rapid that in a few days the patient regained the use of his legs and later of his arms; he began to mutter a few words, though anomia, alexia, agnosia and agraphia persisted. Before a course of intravenous typhoid vaccine could be administered to him, the patient left for his Utah home. Pallor of disks and nystagmus persisted to the end, also absence of abdominal reflexes, which confirmed the first diagnosis. The aphasic state was thoroughly investigated. It was, in the main, of the type of Broca's area, mainly anomia, but it was much more serious than that because of a high degree of agnosia. The patient relearned words recalled to him by repetition. All this has since been largely overcome. He sent a brief letter to his people in St. Johns attesting a great degree of recovery from this most distressing condition.

III: Ariboflavinosis Glossitis

Two cases of this type of glossitis have been observed here. The condition, recently recognized, is rarely pure, being generally combined with niacin deficiency. There may also be an associated infection on a bacterial basis of the adjoining salivary glands, the result of inferior resistance to infection as well as nonutilization of the B complex vitamins. Riboflavin deficiency was the first in evidence, the distinguishing symptom magenta purple tongue and its granular appearance. The niacin tongue is characterized by great swelling and a gray membrane around the margins. Riboflavin deficiency contributed a cheilosis, fissuring and ulceration at the corners of the mouth. The salivary glands were hyperactive, saliva drooling from the mouth and the tongue protruding. Food intake was impossible and the general condition was poor in consequence. Injections of vitamin B complex, full vitamin feeding orally, local antiseptics, etc., cured the condition in short order.

Contributions to Fight Infantile Paralysis

In the last eleven years the American people have contributed $29,562,742.54 to conquer infantile paralysis, according to a statement made by Mr. Basil O'Connor, president of the National Foundation for Infantile Paralysis, at the annual meeting of the Medical Advisory Committees of the National Foundation, held in New York on September 11th. At this meeting applications for grants to carry on medical research were considered and further plans made for carrying on the fight against infantile paralysis. This money was raised through the celebration of President Roosevelt's Birthday and the March of Dimes, held in January of each year, starting in 1934. Sixteen million dollars, or more than half of the total given, was raised in 1943 and 1944. During the past eleven years almost $15,000,000 of the total amount raised has been left with the counties where raised to provide the best in medical care for the thousands of new patients reported each year.

Of the remainder of this nearly thirty million dollars the National Foundation received approximately thirteen million dollars to conduct its programs of scientific research, education and epidemic relief. One-half has been used by the National Foundation for grants in research dealing with the virus, epidemiology and after-effects of infantile paralysis, education and epidemic aid as follows: Virus research, $2,053,761; after-effects research, $1,405,292; education, $1,179,215; epidemics, $637,548; Tuskegee Institute, $404,256; Georgia Warm Springs Foundation, $825,000—total $6,508,475.

Symposium on Alcoholism

THE RORSCHACH ANALYSIS IN THE TREATMENT OF ALCOHOLISM*

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Although many are familiar with the Rorschach analysis in theory or practice, it may be helpful to say a few general words about this projective technique which uses ordinary ink-blots, requiring only that a person tell what they look like and which then, in turn, tells what *he* looks like as an individual.

In dealing with the alcoholic patient it is of course necessary to have an understanding, as accurate as possible, of him as a functioning personality. Supplementing formal psychiatric procedure and clinical findings, the Rorschach ink-blot analysis contributes to this essential knowledge.

Years ago the possibility of ink-blots was recognized as a way of stimulating individual associations to produce subjective material that could be objectively measured by psychological, scientific standards. Binet especially explored its potentialities. However, no standardized material or methodology was made available until Hermann Rorschach, a Swiss psychiatrist, presented his *Psychodiagnostik* shortly before his death in 1922.

In this monograph (the cornerstone of all Rorschach work), the technique was established as a sound, reliable way of indirectly getting at an underlying personality structure through observing how an individual habitually "projected" himself: what were, and how he expressed, his inner tensions, drives and unresolved conflicts; his basic anxieties; his social adjustments; his personality type; and his predisposition to, or involvement in, certain major psychiatric groups—psychotic, neurotic, constitutionally inadequately endowed, and so on.

The last twenty-odd years have seen the Rorschach test in increasingly wider use, both practically and in research work. Other projective techniques have also come into use: the Murray thematic apperception test, finger-painting, children's play techniques, dramatization of certain situations. A projective technique is one that supplies a stimulus from material that is intrinsically meaningless (or capable of various meanings, interpretations and uses). The individual "projects" himself—his inner thinking and feeling life, or *real* self—when he interprets or uses the material "to make something out of it". "What" he has made can then be evaluated according to psychological test requirements, and the requirements of the technique itself; and a "picture" or "chart" or "x ray" of the personality is produced, and what we might call the bony structure of character is revealed.

Today the Rorschach analysis is considered the most reliable objective method, for it has been used in many hundreds of cases and checked and rechecked by clinical findings. Moreover, although somewhat complicated in evaluative and interpretive requirements, it is easy to administer, can be given to anyone who can see and talk, may be readministered, and as a rule takes less time to give and interpret than other techniques. Another advantage is the fact that it is not cluttered with equipment. All one needs are the ten standardized ink-blot pictures, pen, paper, two chairs and the patient.

You hand the patient the pictures, one by one, informing him that there are no right or wrong answers, and asking him to say what they look like or might be. You write as he talks, noting certain things. When he has finished, you complete the rest of the work involved, and interpret the results. Actually what he says or sees is of secondary importance. It is his method of handling these ink-blots that is the core of the Rorschach test. In from fifteen to sixty minutes you are able to produce his ink-blot x ray.

With the alcoholic patient, how does this Rorschach analysis help? What does it do? It helps, first, in differentiating between types of alcoholics. In general we have the following six groups: 1. psychotic with or without deterioration; 2. neurotic; 3. feebleminded; 4. constitutionally inadequately endowed—genogenic —or "bad egg"; 5. those who drink to narcotize physical or psychic pain—maladjustments, neuroses, sexual difficulties and friction between the neurotic personality and the world; 6. those who have developed from social into abnormal antisocial drinkers as a result of habit, plus time, plus body changes, and strains of life.

Sometimes a patient is a borderline case and, because of time, financial and other factors, it is important to know which border he is nearest to—psychotic, organic, or "bad egg" group. A Rorschach analysis here provides objective data.

One day a patient entered the office, unannounced, stating that he knew he needed help for an alcohol problem, and wanted to cooperate one hundred percent. He had been discharged from the Army on a "psychoneurotic basis". He gave us a list of somatic complaints, interlarded with self-defensive accusations against the Army, "which had made him what he was". He said that he would like to go to a private hospital and work as a staff member in return for his board and treatment.

His was the typical "bad egg" Rorschach x ray of the no-good alcoholic who, if he is to be helped, must be treated for months or years under a disciplinary protective supervision. Briefly summarized, the analysis showed better than average intelligence (other tests made at the same session gave him a very high I.Q.); completely high-handed behavior; no practical adjustment to life; egocentric, immature orientation,

*Presented on September 12, 1944, at the annual meeting of the American Association for the Advancement of Science, by the Research Council on Problems of Alcohol and the Committee on Alcoholics of the Welfare Foundation of Cleveland.

with temper tantrums; a shifting of responsibility to other people, and basic intellectual dishonesty.

He was told he would have to come under our care for at least four weeks as a patient on a regular paying basis. This, he said, he could not afford, and it was recommended that he apply to the Veterans' Bureau for treatment at the U.S.P.H.S. Hospital in Lexington, Kentucky. We heard no more from *him*.

Excluding the psychotic, markedly organic, acutely intoxicated and feebleminded persons, who should, of course, be immediately hospitalized, de-saturated, medically treated for the acute alcoholic condition, and placed in either a state hospital or workhouse, if private mental hospital facilities are not available, we must think, in practical terms, about the patient who comes or is brought for help either in, or just out of, an alcohol bout.

First, does he need hospital, that is, medical care, because of marked vitamin deficiency, the result of inadequate food intake while drinking, etc.?

Second, does he need the protection of a mental hospital?

Third, could he "float" on the outside and be treated extramurally?

Fourth, what are the financial factors, the desires of the patient and family, etc.?

Therapy in its broad sense—and it must always be considered in this sense—includes: relationship between patient and physician; placement (hospital, farm, office); psychotherapy; cooperation of relatives and friends; long-range plans with follow-up; and the goal—stated at the outset—of total permanent abstinence for life. Like garlic, there is no such thing as a little alcoholism. If a man is an alcoholic, that is, unable to handle liquor, yet unable to leave it alone, so that it interferes with one or more of his important life activities, the only possible "cure" for him is to learn, on a daily basis, under psychiatric guidance, to live with himself and others in a reasonably contented, efficient and productive way without alcohol.

Obviously, to learn this, to become re-educated, a patient must have, or obtain, insight concerning himself, his drives, his deep underlying anxieties and fears, and his personality liabilities and assets. Even more obviously, in order to guide an individual so that he does get a constructive self-understanding and control, the psychiatrist must know more about the patient than his name and the fact that he drinks too much.

Rule-of-thumb measures, based on experience and intuition, are not always infallible. Moreover, with today's accelerated pressures and demands, most of us do not have sufficient time to permit an adequate sifting and weighing of facts in order quickly to reach a "good feel" of the patient. It is here, as a time saver and short-cut, that the "ink-blot analysis" can help like a third hand.

When properly interpreted, among other findings this remarkable x ray reveals what type of psychiatric personality make-up we are dealing with—neurotic, with or without overly aggressive drives; predominantly psychopathic make-up; schizoid or oddly mentating, the jagged-edged peg in a round hole; manic-depressive without evident psychosis, etc.

A young married doctor was hospitalized for acute alcoholism and drug addiction. His past history showed marked emotional instability and psychopathic traits, including theft, professional dishonesty and indiscreet and unethical sexual activity. After the toxic condition cleared up, he began demanding his rights and was generally and specifically a trouble-maker, stirring up the other patients, annoying the nursing staff, and acting in a hostile manner toward the physicians who were not only sincerely desirous of helping him, as a patient, but for the additional reason that he was also a physician.

An outside consultation was arranged, with the idea that a psychiatrist not associated with the hospital might be able to establish interpersonal contact with him. His attitude, however, remained the same. Kindness was tried and failed. Sternness was tried and failed. Appeals to his professional reason and to his personal pride were likewise unavailing. The feeling was that we were dealing with a psychopath with some neurotic traits. His wife was told that he should have a long-term hospital stay and disciplining, but he prevailed upon her to take him out, and when last hear from he had run off with another woman.

His Rorschach analysis showed him to have marked neurotic traits and psychopathic drives superimposed on an essentially schizoid personality that had never been able to adjust to life, people, or reality in any sense. Strong explosive elements in his emotional make-up rendered him helpless and inaccessible to reason. Because of the basic feeling of "being alone in the world" and the schizoid structure, he was a victim of a severe psychiatric maladjustment and personality-illness for which he had never been treated and the symptoms of which, mental and behavioral, he attempted to allay by alcohol and drugs. It was anticipated that he would continue to get into worse and worse difficulties unless his wife recognized that he was ill. A strong possibility of suicide was present.

Rorschach findings also indicate the level of maturity—good judgment, discretion and control of emotions—which helps decide whether the patient who is not acutely intoxicated should go to a mental hospital, farm arrangement, or could be treated extramurally.

For example, a young woman came with a friend for help concerning alcoholism. She had fairly good understanding of her sexual and social difficulties, but at the time of examination stated that she did not want to go to hospital, that her drinking was entirely due to parental factors and a life-long unhappy home situation. What she wanted was a job and some pills to help her feel less tired and pulled through a knot-hole, and a place to rest.

One felt that her aggressive attitude and expressed unwillingness to undergo hospitalization, although it was clearly indicated, showed her to be on the immature side and that she would have to be tactfully but firmly handled with no acceding to demands or requests. A Rorschach analysis, however, revealed that she had good judgment, discretion and brakes; that her attitude towards life was a responsible one; that she had true insight regarding the deep tensions associated with her parents and people; that her aggressive drives were in proportion to her productive ability.

With these findings as a guide, we suggested that she "rest" at a nonhospital institution for a few weeks to allow us to study her further, during which time

she could get her pep back and make tentative vocational plans. Later, with the help of her friend, she got a job out of town, was discharged and put on office therapy. It is now nearly a year since she first came to us. She has made an excellent work record with advances, has not had a drink, reports in regularly rain or shine, and has established healthy, happy relationships of a non-overt homosexual nature.

The Rorschacher analysis can be an important time-saver in therapeutic interviews, as it points out the fundamental inner stresses and attitudes, thus helping one to go directly to the basic problem of maladjustment. These are of course discoverable and observable in the therapeutic situation but considerably more time is required properly to assay and weigh their relative significance.

In some cases, time is almost at a premium. For instance, the executive businessman alcoholic often presents a severe and difficult problem of personality maladjustment. But, "nothing is ever wrong with *him*", "he's perfectly normal", "his drinking is much exaggerated".

As a person, he invariably has the little dictator attitude—characteristic of the nursery-darling—and his button-punching, telephone-banging, take-a-letter-Miss-Simpson habits make him especially inaccessible to plain folks and practical living. Used to having his own way and to being "padded" by the obedient homage and service of employees, and by the prestige of the company name, he usually develops a drinking problem as a continued "padding" and "bolstering" of his own unadmitted feelings of insecurity, inadequacy and actual lack of confidence.

Thus, when in hospital and removed from his nursery and from alcohol, he has nothing to dress himself up in except behavior-patterns that are unrealistic to the hospital world. He blusters, growls, sulks, and delivers what he thinks to be an ultimatum: "I plan to leave here next Thursday. There's a big deal coming off I have to check on." He bawls out the nurses, refuses medication, calls psychiatry a "good racket", brags about his business acumen, and rarely, if ever, admits to having a drinking problem. It's his wife that thinks he has, but, he declares, "she is one hundred percent wrong". (Incidentally, in her handling of him she usually *is* one hundred percent wrong and, as mentioned later, her cooperation, understanding, and, at time, willingness to be psychiatrically treated herself, are all essential for lasting good results.)

This businessman type needs a firm hand, skillful maneuvers to break him out of ambush, and limitless patience—one might say the patience of saints—from the therapist. Even when these requirements are met, successful results are rarely obtained. In fact, while reluctant to take a pessimistic view, one might say that, *as a group,* the businessman executive alcoholics are nearly hopeless.

Nevertheless, we try to do our best when one of this group presents himself for help, or arrives via ambulance with acute delirium tremens..

Remembering that one must make hay while the sun shines, we usually subject our businessman to a Rorschach analysis as soon as possible, in order to get to his vulnerable points directly, and so get in at least some work on personality rehabilitation. More than one individual is always involved in the alcohol problem and our medical-psychiatric duty is to attempt, in so far as practically feasible, to help with the total situation involving the individual, family, and community.

Inner stresses, deeply submerged, were clearly evident in the Rorschach record of a married, business engineer from the Middle West.

Among other findings were: "aggressive forcing of issues, losing his temper when things do not go his way; marked critical intolerance; sensitive, but usually too self-centered to be more than superficially considerate of others, and more apt to take umbrage at trifles; obsessive petty attitude throughout, with depreciatory ridicule of others; reaction to authority one of rebellion and almost compulsive drive at self-assertion; failure to emancipate from strong mother attachment with subsequent anxiety and ambivalent attitude towards women and his own sex rôle".

"Sex" and faulty sexual adjustment, of course, are often obvious and predominant in psychiatric and alcohol problems. But for this particular patient, sex tensions were deeply hidden from his conscious awareness because of characteristic "successful" he-man exploits.

Likewise unknown to him was his attitude toward authority, which prevented intelligent discrimination between situations when to yield gracefully was really to "dominate", and other situations when he should stand pat. Yet, in job after job, it was this lack of discrimination—tact, he called it—that had kept him from making deserved advances in his profession.

We had, then, a man who, in spite of bluster and brag, was deeply insecure, and who among other lessons needed to learn how to handle his temper, his *actual* attitudes, and his habit of defensive belligerence—which he considered was the hallmark of leadership.

For many days and weeks he refused to admit any insecurities; insisted that everyone always thought highly of him; that he thought highly of everyone, also; and that the "run-ins" of the past were due to competition and other individuals' wanting to "get ahead" and not caring who got hurt.

However, after a rather relentless therapeutic attack, he crumbled somewhat, and later acknowledged that "he was his own worst enemy". This acknowledgment did not prevent his soon declaring himself cured, and discharging us at the end of a few months.

At the end of another few months we were again asked to help out when he resumed drinking; and a crestfallen patient he was—for several days. But, typical of his group, as soon as he got "his health" back, he was cured again; this was wrong, that was wrong, this was uncomfortable, that was distasteful, "you people know your business but" he didn't need to be treated like a baby, in short: "Thanks, doc, for all you've done. I'll be seeing you, feller!" (Only, he won't be seeing us again, for after a patient has once broken through treatment it is nearly impossible to re-establish the therapeutic contact. That he will be seeing some doctor again is a dead certainty—if he himself is not dead before.)

Thus, at the first interview, which often takes place at the office, or early in hospital treatment, ink-blots can tell you, the doctor, why your patient drinks.

We must remember that many sincere and intelli-

gent persons do not know "why they drink". When sober, they are rarely *conscious* of disturbing physical or emotional difficulties and are, therefore, unlike patients with other psychiatric or medical problems who have definite complaints (poor sleep, anxiety, nausea, headaches, etc.), and who, although they may not be able to say why, can at least tell you *what* ails them.

Various "reasons" may be given—a nagging wife, a non-understanding husband, an impossible boss, illness or injury. These "reasons" are, however, factors in, not causes of, the alcohol problem. Biographical evidence, when supplied, invariably shows that the roots of drinking—a need to escape or be narcotized—lie in early childhood personality reactions to the environmental climate, with subsequent faulty development of sentiments, attitudes and resulting behavior patterns in interpersonal relationships.

The ink-blot will reveal these patterns and other drives and tensions and so aid in helping you to handle your patient with requisite tact and firmness, solidly based on objective knowledge of *who* he is, what are his deep sentiments and attitudes, and how best to help alter or modify these mechanisms, emotional patterns, and values or goals in life.

Exemplifying this is the case of a middle-aged, pleasant, married woman with a grown daughter, who had been drinking for many years. A previous hospitalization elsewhere had failed to achieve lasting benecial results. Externally and objectively there were no severe strains or worries that might produce the need for narcotization. Her husband was kindly and a good provider. She had many friends, prior to several years before admission for drinking. Her health was good. One wondered if this was a case of "poor egg", or personality deterioration as a result of years of social drinking.

A Rorschach analysis was made at the end of the first four weeks, and the underlying structure showed a marked obsessive petty approach, with tensions of a sexual and egotistical nature and recurrent depressive moods of which, subjectively, the patient was not aware. Although she said she had no real reason to drink, she tried to rationalize her problem on the basis that her husband "picked" and "nagged" her all the time—no matter what she did he was never pleased. In spite of his occasionally irritating suggestions about housekeeping, she herself was the nagger; but, because of a more than usual amount of social politeness in her make-up, she masked this tendency, never coming out into the open either with criticism or any constructive action. Rather, she took refuge in solitary "stolen" drinks, and then used her husband's reaction to her drinking as a "reason" for feeling abused and so needing another drink to relax and enable her to endure his "sarcasm".

Her behavior in hospital was consistently on the passive side, socially agreeable, and willing to do whatever was asked of her. Later she would indirectly accuse the staff of "imposing on her good nature" and exploiting her. Her whole approach to life was one of a spoiled child who desired to be the center of the stage but would assume no responsibilities herself. A certain holy air of "martyrdom" encompassed her.

Rorschach results indicated that therapy would have to be a long-term situation; that activities directed away from minor issues and petty details were important; and that we should have to expect—from time to time—a sit-down strike, with or without antagonistic manifestations of an inherently noncooperative attitude. With this patient we had to ignore the pleasant-appearing cover on the book; to keep in mind that we were dealing with an obsessive, immature, diffusely neurotic individual whose real self was hidden under many layers of rationalization with faint paranoid coloring, and that, by many practice-perfected devices, she would often succeed in getting her own way.

Clinically this was proved by her underground methods of working on staff members, playing one against the other, and always using her husband's minor faults as major cruelties which "emotionally crushed" and "kept her from getting well".

Factors in Successful Rehabilitation of Alcoholics

Experience indicates that successful rehabilitation of alcohol patients depends on seven factors.

1. Careful selection of patients, that is, voluntary patients with average or better intelligence, some level of emotional maturity, undamaged brains, with place of treatment depending on business, home and social contacts, etc.
2. Personality of the psychiatrist. We feel that, ideally, it is important for the psychiatrist and staff members to be total abstainers.
3. Distributive analysis and synthesis in psychotherapy.
4. Interpersonal relationship of patient and therapist.
5. Suggestive influences.
6. Re-education.
7. Continuous follow-up through visits, letters, phone calls, and considered by the patient, his family and associates as being of the most serious importance, similar to that of repeated pneumothorax and subsequent check-ups for tuberculosis patients.

Of these, the cooperation of family and friends is of great importance. It cannot be overemphasized. Without the moral and sincere support of the mate or relative or friend one cannot hope for lasting good results. Miracles do happen but psychiatry cannot depend on miracles.

Many times, due to lack of this cooperation, one is foredoomed to failure. No measure can be carried through without means of enforcement. Interesting from several points of view are the following Rorschach records of patients whose relatives failed to understand the importance of the alcohol problem and the need to cooperate during and after treatment.

Two male patients were given a Rorschach analysis after they had been in hospital two weeks. Their "x rays" were amazingly similar, showing marked, severe neurotic features, obsessive tendencies with somatic indications, unrealized ambitions and a basic depressive trend.

Both were married, but otherwise their overt life patterns were dissimilar. There was a twenty years difference in age; a difference in educational and vocational backgrounds, the older man having been a manual type worker all his life; a marked sex activity difference—the same patient reporting many nonidealistic relationships; and, because of the difference in age, a difference in alcoholic intake over many years.

Based on Rorschach findings, without benefit of other objective or subjective data, the younger man was interviewed and the following material elicited.

For three years prior to admission he had suffered from and been treated for severe chronic *colitis*. Of husky build and with some aggressive traits and mannerisms, he felt himself inadequate and at time nervous, characterized by petty, temperish, irritable spells and a nagging insistency about details. The other patient also stated that he was subject to needless worry, to irritable spells, that he had butterflies in his stomach, usually associated with prolonged dull headaches.

Offhand one would expect better results with the younger man, who had socalled better educational and vocational advantages. His wife, however, in spite of past difficulties due to his drinking, could not see the importance of therapeutic rehabilitation. She stated that it would be dreadful if he thought he was neurotic! In a few words, we were unable to get to first base with her. After six weeks of office follow-up, the patient stopped his visits, in spite of his *expressed* desire for treatment. Two months later we heard that he was again drinking and in difficulties.

The other man is still under our care and guidance; we see him each week. His wife consistently has given us reliant and reliable cooperation—even during his impatient periods and periods when her own emotional judgment was swayed by his quite convincing assurances of being "cured" and ready for and needing a job.

To repeat, the Rorschach analyses of both of these men were nearly identical. The findings pointed to a basic neurotic structure capable of successful treatment but requiring time and an approach directed towards "seeing whole" rather than towards a painstaking investigation of details, since both were inclined to be obsessive and bogged down in nonessentials. Again, the life experiences and situations were dissimilar, yet we dealt with the same type of personality structure. But one man, in spite of the handicap of his age, had a wife who was capable of helping him "stick to the course already charted". He has not had a drink for ten months, and is now productively engaged. He has learned to handle his mood swings and they have become far less frequent and intense. He is rarely irritated by inconsequential events or other people's annoying mannerisms, and his discouragement and sense of futility about the future—based on age and unhappy past experiences—have been replaced by a mature and healthy outlook.

We have on file another arrestingly similar set of Rorschach x rays—one of a man, the other of a woman.

Both patients came to us unaccompanied. Both had a severe drinking problem and had failed previously to benefit from treatment elsewhere. Both had a history pointing to psychopathic make-up: many jobs, inability to learn from past mistakes, etc. Both were married. Cooperation from the mates is easily summarized. We heard nothing from the wife. From the husband we received two telephone calls.

Both patients were given a Rorschach analysis at the initial interview. These findings constituted the only data we ever received except that supplied us by the patients themselves. In both cases the record was one of marked emotional instability and marked, propulsive, violent emotional forces that threatened to overpower inadequate thought controls and leave the individuals wide open to primitive emotional "explosions". In addition—and with the alcohol patient this is a very important factor—both had an exaggerated sense of personal importance and "prestige". With personality immaturity and emotional instability, this prestige factor is frequently the weight that tips the scale. Skillfully utilized in therapy, one can establish a good beachhead on this terrain of pride and prestige and so get the ego-ideal working in behalf of the total personality and on a constructive basis. Many people drink to escape from feelings of inadequacy resulting from an incompletely oriented and purposively directed prestige drive. But this element is dynamite. We all know from practical experience that false pride drives many a man and woman to self-destructive activities. With the alcohol patient, especially, there comes a time when this sense of prestige turns outward constructively—or inward, with fatal destructive finality.

For this man and woman, therapy and placement were clearly indicated by their Rorschach analyses. A long period of time in a protective environment was essential, with discipline, retraining and direction of their drives and behavior patterns, and practical commonsense adjustment to reality to break up their habit of fantasy and compensatory daydreams. In spite of superficial social adjustment—the ability to carry on light conversation and banter, and to say "please", both were poorly adjusted in their social relationships, with a tendency to feel misunderstood and abused.

Moreover, in both cases, neither mate was interested enough to appear in person, or help in any way. These foundlings just arrived on our doorstep.

One patient after a brief hospital stay had so great a prestige drive that he minimized the seriousness of his drinking problem, and besieged his friends to get him an executive Park-Avenue-type job. Medically and psychiatrically he was in no condition to leave, and although the financial worry would have been eliminated by placing him on a work-patient basis, he would listen to no suggestions along this line. The other patient soon tired of the mild restrictions and monotony of daily "hospital" life. Both patients were so deeply emotionally led—or driven—that with no one else to back us up we could not get a hold on them and they could not get a hold on themselves. In such an impasse one looks for the worst to happen. It did. Within the year both patients killed themselves.

From the point of view of the Rorschach analysis as an aid in determining therapy, including placement, these two records are highly significant. Outwardly, both patients were aggressive, rather self-assured, not visibly depressed, nor consciously had they any disturbing symptoms save a vague restlessness. Only through means of the Rorschach analysis was the possibility of suicide indicated; and there it was clearly present in the emotional instability, emotional force and push, lack of "brakes", wide moodswings and *basic* depression in the personality, poor adjustment to reality and an exaggerated sense of personal prestige. In cases such as these, long-term therapy in a protective environment is the only possible safe plan.

It is important to know whether a patient has progressed or regressed during therapy. If the latter, the presence of a severe psychiatric illness, without any as yet overt or manifest symptoms, must be ruled out. A readministered Rorschach analysis is of help in both instances, and is also helpful in decisions such as,

transferring a patient from a mental hospital to a less protective environment, discharging him to office therapy, or recommending him for a job.

We had one patient, a professional man, thirty-two years old, married, who had been treated for two weeks about a year before coming to us, at which time he had been drinking for six months on a spree basis. His first Rorschach analysis showed him to be depressed, aggressive, with an attitude of what-the-hell, capable of producing more than he actually was doing, and subject to irritable moods. A tendency to shirk adult responsibilities was present and a poor social adjustment with sulky rejection of social situations.

Three months later the Rorschach analysis was readministered while he was still under treatment. It revealed a more stable prevailing mood, a shift in aggressiveness to a better practical adjustment, and more willingness to assume adult responsibilities, commensurate with his known and proved abilities.

We needed to know what changes in attitudes and emotional patterns had resulted, for this man was scheduled to work with a large group of people in a supervisory and executive capacity. The findings of his second Rorschach analysis indicated that good progress had been made and that his ability to get along with people had vastly improved on a mature level. In spite of some unfavorable external factors, subsequent actual success of this patient in his new work showed that the Rorschach had accurately recorded fundamental changes in the personality structure as a result of therapy.

In general, to sum up briefly the problem of alcoholism and the alcoholic personality, as such, that we must deal with and handle, we expect to find, clinically, any or all of the following personality motivations:

A self-pampering tendency which reveals itself in a refusal to tolerate any unpleasant state of mind—boredom, sorrow, anger, disappointment, worry, depression, dissatisfaction, and feelings of inferiority or inadequacy. A childish demand for "I want what I want when I want it because I want it" perhaps expresses the attitude of many such individuals toward life.

Also present may be an instinctive urge for self-expression without determination or staying powers to organize this urge into creative action; a more than usual craving for emotional experiences which call for the removal of intellectual restraint; powerful hidden ambitions without the necessary resolve to take practical steps to attain them, with resultant discontent, irritability, depression, disgruntledness and general restlessness; a tendency to flinch from the worries and responsibilities of life and to seek escape from reality by the easiest available means; an unreasoning demand for continuous happiness or excitement; and an insistent need for the feeling of self-confidence, self-importance, calm and poise that some obtain, temporarily, from alcohol. Self-destructive tendencies and latent or overt homosexuality are not infrequently found in the alcoholic personality.

The Rorschach ink-blot analysis, in one session of at most two hours, gives unbiased evidence of the presence of any or all of these factors. As in other situations, the more you have to deal with, the more you need to know what you do have to deal with. Correlating the foregoing clinical findings, experience with the Rorschach technique as used with nondeteriorated, nonpsychotic, nonfeebleminded alcoholic patients has led us to expect various findings, including:

1. More than usual W percent—a high-handed approach without regard to the requirements of reality; aggressive drives without purpose or goal.
2. Few M and low or high F percent—inadequate, or faulty judgment and discretion or "brakes"; ambition exceeding capacity to produce.
3. Handling of plate IV with rejection or aggressive popular W and *depreciatory comments as an indication of a nonadult attitude towards authority.*
4. High CF with possible C—*strong to violent emotional forces.*
5. Sweeping or forced W on VIII, IX, X, with CF, F- and S—*basic difficulty in social situations.*
6. (H) on III or poor M or MC^1—*basic difficulty in interpersonal relationships.*
7. High A and Ad—*tendency to shirk adult responsibilities.*
8. No organizational W or low D percent—*lack of perseverance.*
9. Use of S as receptacles and Ad on IV or VI viewed as tacked up—*with men, desire to dominate women.*
10. High Dr percent and high Fc—*hypersensitivity and paranoid trends.*
11. Unusual use of background of blots—*negatively aggressive, resistive, or schizoid make-up.*
12. Refusal to cooperate by total rejection or easy popular responses—probable bad egg customer.

In addition to these, although, of course, there is no one definite alcohol personality "type" as such, we have found that a W-CF-A-P "formula" and including (9), as suggested by Florence Halpern, psychologist, Bellevue Hospital, New York City, who has worked intensively with this technique, is often found in the Rorschach analysis of an aggressive psychopath, or in that of the individual with some psychopathic traits, who drinks to excess as a means of "satisfying an insatiable demand for continuous happiness or excitement".

Frequently, latent or overt homosexual trends are revealed through a combination of: marked anxiety on VII, with midline centering, indicating mother attachment; ambivalence on III—men or women because of the high heels and breasts; acute shock in one of various ways on IV—the "father card"; and a tendency to see Walt Disney characters on VIII, IX or X—especially clowns on IX in the orange portions.

The "prestige-drive" is present in responses including, coat-of-arms, shields, jewelry, insignias and general verbal behavior, such as expatiating on life experiences, or abilities, in association with responses, such as, "This is a bearskin. It reminds me of bears I've trapped and skinned many a time. I've done a lot of big-game hunting . . . fishing . . . etc. . . . etc." This type of verbal behavior is, of course, to be distinguished from that of the neurotic, the obsessive, the organic, and the psychotic (manic-depressive in the manic phase, or schizophrenic).

Conclusion

In conclusion, in our experience with patients who have an alcohol problem, the Rorschach analysis has been a reliable objective aid in the following instances of determining therapy and working with this type of psychiatric problem:

1. In differential diagnosis of the partial or total psychopath; of the organic, psychotic or feebleminded alcoholic; of the neurotic, the situational, the neurotic-schizoid or the psychopathic-schizoid alcoholic with some neurotic traits.

2. As an aid in placement.

3. As a time-saver in therapy.

4. As an aid in making therapeutic plans and safeguards.

5. As an aid in uncovering basic factors and mechanisms (anxieties, tensions, deep conflicts, specific attachments or hostilities or fears, drives and urges and adjustive techniques).

6. As an aid in obtaining *objective* evidence and data regarding the above.

7. As a means of checking up on progress (or regress) during therapy.

We consider the Rorschach analysis as probably the best practical, objective diagnostic scientific method of indirect personality analysis and study and for use in borderline or difficult cases. Knowledge of and ability to use this helpful "tool" will undoubtedly become increasingly important for all workers in medical psychology and in associated fields of human behavior. Its use with those who have an alcohol problem serves not only to x ray the personality structure and underlying difficulties for treatment procedures with the existing problem; it serves also in the field of preventive therapy to indicate the possibility that certain personalities may, unless given adequate preventive-supportive therapy (prophylaxis), become addicted to the use of alcohol and other drugs.

National Committee on Alcohol Hygiene

The National Committee on Alcohol Hygiene, Incorporated, with national headquarters in Baltimore, Md., held its first institute on this community and national health problem, on September 14, 1944. About seven hundred representatives of Baltimore's professional and civic life attended. At the afternoon session Dr. Robert V. Seliger, executive director of the committee, instructor in psychiatry at the Johns Hospkins University Medical School, and medical director of the Farm for Alcoholic Patients, Ellicott City, Md., spoke on the effects of alcohol on the individual. New approaches to understanding the alcoholic were discussed by Lawrence F. Woolley, clinical director of psychiatry, Sheppard and Enoch Pratt Hospital, Towson, Md.; Wilson Shaffer, Ph.D., dean, College of Arts and Sciences, Johns Hopkins University; and Victoria Cranford, Rorschach worker and psychotherapist, Haarlem Lodge, Catonsville, Md. Robert M. Lindner, Ph. D., U.S.P.H.S., psychologist and psychotherapist at the U.S. Penitentiary, Lewisburg, Pa., spoke on alcoholism and crime.

At the evening session, Dr. Samuel Hamilton, president-elect of the American Psychiatric Association and director of the Hospital Division of the National Committee for Mental Hygiene, presided. Among the speakers were Dr. Robert V. Seliger, whose topic was, "Alcoholics are Sick People"; Dr. Lawrence Kolb, director, Mental Hygiene Division, U.S.P.H.S., and Dr. Haven Emerson, professor of public health, Columbia University. Dr. Emerson spoke on "Alcoholism and Public Health", and Dr. Kolb discussed this problem as it is viewed by the U.S. Public Health Service.

The purpose of the National Committee on Alcohol Hygiene is to disseminate scientific information to the public through various *educators* on the subject of alcoholism with the primary view of *educating* individuals and the community about alcoholism, as distinguished from social drinking, and the significance of this medical, psychiatric problem in its effects on, and relation to both the individual and the community. As, obviously, one cannot have alcoholism without alcoholic beverages, these scientists also feel strongly that the personalities addicted to (or ready to be addicted to) the narcotic, alcohol, whether as an escape or a crutch, have alcoholism as a secondary illness—a personality habit. Excluding clearcut psychiatric reaction types who may drink to excess, the fundamental difficulty is a psychiatric problem of unadjusted or maladjusted personality-organizations with faulty values and attitudes and goals in life. Many stresses and strains in these times and in the individual himself, contribute greatly to producing alcoholism, the culminating, overt sign of inward difficulty, disharmony, and illness. Thus, merely to take away alcohol is begging the question. If those who clinically are found to have an alcohol problem could not obtain alcohol in any form, nevertheless continuing to present a psychiatric problem, they would seek some other means of narcotization or escape, and thus prolong and postpone remedial measures for the basic conflict and illness.

At this first institute held under the auspices of the committee, speakers and discussants concurred that alcoholism is definitely a major health problem, directly and indirectly affecting the lives and well-being of many other individuals; and that this problem needs to be met by vigorous nation-wide, concerted scientific prophylaxis and diagnostic-treatment facilities. To this end, the National Committee on Alcohol Hygiene, Inc., is cooperating with other groups in the country who have similar purposes.

At the present time, the following services and educational aids are available through headquarters of the National Committee on Alcohol Hygiene, Inc.: 1, *Alcohol Hygiene,* a bimonthly publication presenting material to be used for educational purposes; 2, scientific medical-worker speakers for lay and other seriously-minded students of alcoholism; 3, a research staff to organize and sponsor institutes; 4, a clearing center for proper evaluation of published material by the scientific research committee and for distribution of acceptable reprints; 5, consultation service for community chest and other groups to aid in the organization of medically and psychiatrically supervised diagnostic-treatment alcohol clinics; 6, material on fundamental preventive measures based on practical medical-psychiatric knowledge and experience; and on actual treatment of individuals with an alcohol problem.

Members of the executive staff are: Dr. Robert V. Seliger, director; Robert M. Lindner, director of editorial and educational projects; Dr. Lawrence F. Woolley, director of clinical investigators, and Victoria Cranford, director of scientific investigators.

National headquarters and editorial offices of the National Committee on Alcohol Hygiene, Inc., are at 2030 Park Avenue, Baltimore (17), Md.

Editorials

Therapeutic Uses of Oxygen

When one reads now and then of "advances in medicine" he may have a somewhat cynical feeling that "wishful thinking" is still with us in spite of all the setbacks and disillusionments our art has always known. But there come to mind the wise words of Tennyson: "Science moves but slowly, slowly, creeping on from point to point." So elusive is truth. Great discoveries are often made only to be partially or completely forgotten.

Joseph Priestly, English physicist, flourished between 1733 and 1804. He discovered oxygen and added it to the list of "elements". It was simply a curiosity for many years, then somebody re-discovered it and found out how important it was as an ingredient of air, water and food. But its use in medicine was still unknown until a few years ago, when as a last resource it was given to patients dying of pneumonia. Even so, it failed to gain recognition as a dependable agent. Bacteriologists know that it is a potent enemy of anaerobes, but this may be news to some of us practitioners. Many years ago this writer "cured" a case of Ludwig's angina of the neck, in which Bacillus welchii was the causative agent. There was a foul, stinking, gangrenous mass which yielded to hourly irrigations with "full strength hydrogen peroxide". Recovery was almost miraculous, and good health continued for ten more years until the man was carried off by that "friend of the aged", pneumonia.

All this was brought back to mind upon reading in the *New York State Journal of Medicine,* November 15, 1944, an article written by Dr. John H. Evans, of Buffalo, entitled, "The War and Oxygen Therapy". For many years Dr. Evans has been a strong proponent of oxygen therapy, and he has a right to be heard; for he and his associates "have administered one hundred percent oxygen with positive pressure to over one thousand four hundred patients". It would seem that now is the time for further "experimentation" with oxygen inhalation therapy because of the vast amount of "material" in the form of war casualties. To mention a few of the uses to which this therapy has been put, there are pneumonia, shock, gas poisoning and extensive burns. Anoxemia is a prevalent condition in the air forces, but the proper dosage must be calculated to be effective.

While one hundred percent oxygen might not be tolerated by a perfectly normal, healthy man, it can be safety given for hours to those in need. Oxygen has been administered to pneumonia patients by "general men" for a long time. If it has seemingly failed, says Dr. Evans, it is because it was given too late and ineffectively exhibited. How can one get it into a lung which is so consolidated that nothing can enter? In such a case it can be injected subcutaneously, but "there is no explanation why the comparatively small amount . . . should relieve . . ..anoxemia". In fact, it will not, if the peripheral circulation is at too low an ebb. In a series of one hundred cases of pneumonia of varying types the patients were given one hundred percent oxygen under positive pressure *early* in the disease. The death rate was only six percent!

In shock and in gas poisoning the probable terminal cause of death is anoxemia; therefore, in such a desperate situation one hundred percent oxygen under pressure should be the rule, but the "tendncey is to discontinue the use of oxygen prematurely".

Perhaps the most remarkable case cited by Evans is that of a nine year old girl who suffered third degree burns of more than two-thirds of her body surface. She was *in extremis*. Soon after oxygen therapy was begun, her mental condition cleared, the cyanotic burned areas changed to pink, and eventually the burns healed completely *without skin grafts.*

The subcutaneous injection of oxygen hastens the healing of open wounds. It improves the blood supply, lessens discharge and bacterial activity. This is a clinical observation only, and needs to be supported by research. In this sense the observation is "unscientific".

Dr. Evans supplies a "list of uses" of subcutaneous oxygen in wartime medicine which seems a little too inclusive. However, Barach in his *Inhalational Therapy*, 1944 edition, seems to think that the "dangers" of oxygen therapy have been greatly overemphasized, and that it is a safe agent when its use is based on good judgment. If that is true, why hesitate to continue its use?

The Prolongation of the War

After our tremendous efforts during the past three years and the excellent success that we had on the Western front, we were all optimistic that the war was to end in the near future. Recent developments have changed our optimism, and it now seems that the struggle will be prolonged for some time. This delay in victory will multiply the death and destruction and disease throughout the world. Here at home we shall be forced to greater endeavor and there will be a greater pinch in the things that we all feel that we require.

This, however, is a small part of the cost. It may be uncomfortable but not unbearable; and when we compare our status with that of our men on the fighting fronts or with the peoples of the other belligerent countries, our situation is indeed a fortunate one. In Europe and in most of Asia, millions are living on the thin edge

of poverty and cannot adequately meet their essential needs. Millions will be hungry and cold and undernourished; millions will suffer privation and want. We won't attempt to discuss the needless futility of it all, but we must face the results in a realistic fashion.

Reports have it that the undernourished and badly-housed peoples in the belligerent areas of the world, having less resistance, are victims of various transitory and chronic ailments. We are going to have a very sick world, physically, mentally, and morally. We who are least affected will have the greatest responsibility. We have entered the struggle and shall be obliged to aid as best we can the casualties, both military and civilian; those whose wounds are apparent and those who are just as deeply wounded by the lack of food and shelter.

With each day of prolongation of the war our task becomes greater and the physicians of the world will have an ever increasing share in these responsibilities. The physicians of the country, who had no part in the creation of this diabolical struggle, must minister to those who are injured now, and will be obliged to minister for a long time to come to those whose injuries are less apparent but which will endure much longer.

It is truly a colossal and heroic task and we might as well face it. We most sincerely hope that our readers will garner the best that can be obtained from this war-torn world and will give as they always have in the past the best they can offer to those who suffer from this monstrous maladjustment.

Industrial Misfits

Of course there are numerous misfits in every profession, trade and industry, that is, many persons are not suited to the work they have undertaken. Often it is the monotony of the work which bores them, especially in this machine age where the lust for speed is the prevailing feature. Excitement nowadays has come to be the breath of the nostrils of young persons and most of them will not endure the tediousness of a long training. Expediency seems to be the watchword rather than thoroughness. In industry, youth wishes to learn quickly and refuses to undergo the long apprenticeships of former times during which, although education was slow, at least it was thorough.

At a meeting of the British Association held in Dundee, Scotland, vocational industrial training was discussed. Dr. N. A. Wilson, vocational advisor to the British National Institute of Industrial Psychology, described the cases of fifty men, most of them twenty-five or twenty-six years of age, who had consulted the Institute because they felt they were misfits. Most of these men had made their original vocational choice in an overromantic and escapist manner. Reasons for occupational failures were many, but, according to the speaker, neither lack of facilities for promotion nor lack of intellectual capacity in the employees was a potent cause. His largest group of "misfits" were persons of excellent intellectual aptitude who appeared to be failing because of a lack of temperamental robustness or competitiveness.

Are conditions sufficiently similar in this country to invite comparison? It would be interesting and useful to discover some of the facts. Industrial workers in America, since they are much more cosmopolitan than in Britain, in the natural order of things should be more temperamental. The Englishman is regarded as phlegmatic. Has he changed his spots or rather, has the machine age changed his temperament and mental outlook? The Scotsman, although largely of Celtic origin, is looked upon as cautious and eminently businesslike. His Celtic ancestry often crops up, however, and he is really more emotional and certainly more gregarious, a better "mixer", than the Englishman. The Irishman of the North has the same characteristics as the Scotsman. Indeed, perhaps, most of them have been translated from time to time from Scotland to the North of Ireland. The South country Irishman is very temperamental, but in his own country has little scope for industrialism. The Welshman is descended from the ancient British, and more emotional and subtle than the Englishman.

It is obvious that America, the melting pot of Europe, has within her boundaries a proportionately larger number of temperamental persons than Britain has. As vocational guidance has been in vogue for some time here, there are those who are entitled by experience to speak with authority on the subject of industrial misfits and the merits of vocational guidance. It is an important matter from the psychological aspect.

News Items

Historical and Cultural Medicine.—A combined meeting of the Section of Historical and Cultural Medicine and the Section of Pediatrics was held at the New York Academy of Medicine on Thursday evening, January 11th. The following papers were presented: Notes on the history of the methods of feeding infants, by Dr. Lewis H. Koplik; Historical aspects of poliomyelitis, by Dr. John R. Paul, New Haven, Conn.; Early measles epidemics in America, by Dr. Ernest Caulfield, Hartford, Conn.

Annual Meeting of the A.M.A.—The ninety-fifth annual meeting of the American Medical Association will be held in Philadelphia, June 18 to 22, 1945, instead of in New York, June 11 to 15th, as originally scheduled. It was found that on account of war emergencies the needed facilities for such a meeting would not be available in New York.

Harvey Lectures.—The third Harvey lecture was delivered at the New York Academy of Medicine on Thursday evening, December 21st, by Jean Oliver, professor of pathology, Long Island College of Medicine, the subject being new directions in renal morphology: a method, its results and its future.

The fourth Harvey lecture will be delivered on Thursday evening, January 18th, by Dr. Hermann Otto Laurenz Fischer, research professor at the University of Toronto. His subject will be "Biological and Chemical Relationships between Hexoses and Inositols".

Lectures to the Laity.—The ninety-fifth anniversary discourse of the New York Academy of Medicine was delivered Tuesday evening, December 19th, by Dr. G. Canby Robinson, Washington, D.C. The subject of the lecture was "The Patient as a Person".

Dr. Franz Alexander, of the Institute of Psychoanalysis, Chicago, discussed "Recent Trends in Psychiatric Thought and Future Outlook", Thursday evening, December 28th.

Dr. William C. Menninger, chief consultant in neuropsychiatry, Office of the Surgeon General, Washington, D.C., delivered a lecture on "War and Psychiatry," Thursday evening, January 11th.

New York Pathological Society Centennial.—A meeting of the New York Pathological Society, in affiliation with the New York Academy of Medicine, was held Friday evening, December 15th, to celebrate the one hundredth anniversary of the founding of the Society. Dr. Howard T. Karsner, director of the Institute of Pathology, Western Reserve University, Cleveland, Ohio, delivered the annual Middleton Goldsmith Lecture, his subject being "Pathology, Old and New". Dr. Francis Carter Wood read an interesting paper on the history of the foundation of the New York Pathological Society.

New York Heart Association.—A meeting of the New York Heart Association, a division of the New York Tuberculosis and Health Association, Inc., will be held at the New York Academy of Medicine on Friday evening, January 26th, with Dr. Edwin P. Maynard presiding. The program includes the following papers: Cardiac Enlargement, Its Recognition and Significance by Dr. Harry E. Ungerleider, which will be discussed by Dr. Marcy L. Sussman. Surgical Treatment of Hypertension by Dr. Reginald H. Smithwick, of the Harvard Medical School. Among those who will take part in the discussion of this paper are Dr. James H. Hinton, Dr. William Goldring, and Dr. Bronson S. Ray.

International Spanish Speaking Association of Physicians.—The following officers for 1945 have been elected by the International Spanish Speaking Association of Physicians: president, Dr. J. M. Gershberg, New York; first vice-president, Dr. Ray Lyman Wilbur, San Francisco; second vic-president, Dr. J. R. Goodall, Montreal; third vice-president, Dr. J. A. Lacasa, Nicaragua; general secretary, Dr. William J. McDonough; general treasurer, Dr. F. L. Aron; assistant secretary, Dr. J. Hayn; assistant treasurer, Dr. A. Keesing; recording secretary, Dr. J. J. Kulesar. At the annual meeting of the association, which will be held at the Pythian Temple, 135 West Seventieth Street, New York, Friday, January 26th, the guest of honor will be the Consul General of Brazil, and the scientific program will consist of a symposium on the "six most dangerous diseases".

Clinical Society of Reconstruction Hospital.—At a meeting of this society held on Wednesday evening, January 17th, the program consisted of the presentation of cases of peripheral nerve injuries by Dr. Carl A. Peterson, Dr. Henry H. Ritter, and Dr. David Goldblatt.

Social Hygiene Day.—The American Social Hygiene Association announces that February 7th will be Social Hygiene Day. New pamphlets, posters, exhibits, films, and suggestions for the fight against venereal disease have been prepared, and the program promises to be the best on record.

Associated Hospital Service Increases Benefits.—Increased benefits to the 1,700,000 members of the Associated Hospital Service of New York has been announced by Louis H. Pink, president. Beginning December 1st subscribers will be entitled to receive hospital care during a period of twenty-one days for each separate illness they may suffer instead of twenty-one days for the entire year.. The organization's policy of granting benefits for ninety days at one-half the regular hospital rates will remain in effect for each period of hospitalization. In addition, a cash allowance of $7.25 will be paid to subscribers who may need operating room service at the hospital but who do not become bed patients.

The Procter Gold Medal.—A gold medal award has been established by the Philadelphia Drug Exchange in commemoration of William Procter, Jr., "Father of American Pharmacy." The Procter medal is intended as a recognition of distinguished service in the pharmaceutical field and will be awarded from time to time to American pharmacists, chemists or scientists agreed upon by the committee of the Drug Exchange. Ivor Griffith, Ph.M., Sc.D., will be the first to receive the medal. The award will be made at a dinner to be held in the Bellevue-Stratford Hotel, Philadelphia, on January 23d. The citation sums up Dr. Griffith's distinguished services in the pharmaceutical field as administrator, researcher, teacher, author, lecturer and technical advisor, including the presidency of the Philadelphia College of Pharmacy and Science, the oldest teaching institution of its kind in America.

William Beaumont Memorial Foundation.—A beautifully illustrated booklet has been issued announcing the organization of the Dr. William Beaumont Memorial Foundation at Prairie Du Chien, Wisconsin, where Dr. Beaumont carried on many of his history-making experiments. The Foundation was organized as a memorial to the pioneer physiologist and as an American medical shrine. It is sponsored by a group of eminent medical men and citizens of Wisconsin. Dr. Walter J. Meek, acting dean, University of Wisconsin Medical School is chairman of the advisory board and the members include Dr. Arno B. Luckhardt, professor of physiology, University of Chicago; Dr. Walter B. Cannon, professor emeritus, physiology, Harvard University; Professor Ben Elliott, University of Wisconsin; and Dr. Edward P. Alexander, director, State Historical Society of Wisconsin. The brochure contains an interesting history of Dr. Beaumont and includes excerpts from his diaries as well as his "51 Inferences." Physicians may secure a copy by writing the Dr. William Beaumont Memorial Foundation, Prairie Du Chien, Wisconsin.

New Catalogue of Chemical Publishing Co.—A new catalogue of technical books has been issued by the Chemical Publishing Co., Brooklyn, N.Y., which includes the latest books on chemistry, technology, physics, general science, mathematics, engineering, foods, formularies, drugs and cosmetics, gardening, medicine, metals, technical dictionaries, etc. A copy of this catalogue will be sent free to everyone who is interested in keeping up with the latest technical and scientific progress.

Office Staff Appointments at the Hospital for Joint Diseases.—The Hospital for Joint Diseases announces house staff appointments to fill twelve places on the general rotating service as follows: Eight interns to begin July 1st, August 1st, September and October 1, 1945, for nine months internship. One-half of the number appointed may be permitted to continue for another nine months as junior residents, and thereafter, one-half of the number of junior residents may be continued for another nine months as senior residents, in accordance with the Allocation Plan of the Procurement and Assignment Service. Graduating students and graduates of Class A medical schools are eligible. Interns and junior residents after completion of their service are eligible for service in orthopedic surgery. The Hospital for Joint Diseases is a general hospital featuring orthopedic surgery and treats about 6,000 patients annually. For further particulars and application blanks, address the Director, Hospital for Joint Diseases, 1919 Madison Avenue, New York 35, N.Y.

Combined Meeting of Neurologists and Psychiatrists.—A joint meeting of the Section of Neurology and Psychiatry of the New York Academy of Medicine and the New York Neurological Society was held on Tuesday evening, January 9th. Carbohydrate and electroencephalographic studies on flying personnel with operational fatigue were presented by Major Benjamin H. Balser of Lincoln, Neb., chief of the section of neuropsychiatry and Dr. Bernard L. Pacella of the New York State Psychiatric Institute and Hospital. Lt. Colonel S. A. Sandler of the Army Service Forces Training Center, Camp Lee, Va., read a paper on Camptocormia, the hysterical bent back of soldiers. Dr. George H. Hyslop read a paper on Distant secondary circulatory and vasomotor reactions to electric shock. Dr. William A. Geohegan opened the discussion.

Borden Award.—Dr. Harry Gordon, assistant professor of pediatrics and Dr. S. Z. Levine, professor of pediatrics, at the Cornell University Medical College were joint recipients of the first annual Borden Award to be administered by the American Academy of Pediatrics, "for outstanding achievement in research in nutrition of infants and children". The award was presented at the Academy's Wartime Conference on Child Health, in St. Louis, Mo., and was made for metabolic studies on the nutritional requirements of premature and full-term infants. These studies contribute a physiological basis for individualized feeding.

The Borden Awards, which carry with them a commemorative gold medal and $1,000 were established in 1937 to encourage and give recognition to scientific research in the fields related to the food industry. They are administered by seven scientific associations.

Personal.—Dr. William Worthington Herrick, professor of clinical medicine, College of Physicians and Surgeons, Columbia University, has been elected president of the New York Academy of Medicine for a term of two years.

Dr. J. P. Quigley, formerly professor of gastrointestinal physiology at the School of Medicine of Western Reserve University, Cleveland, Ohio, has been appointed professor of pharmacology and chief of the division in the University of Tennessee, Memphis.

Dr. Walter Lewis Treadway, medical director, U.S. Public Health Service, has retired from active duty for disability incurred in service. Since July, 1941, he had been stationed in Los Angeles as medical officer in charge of public health service activities.

Major Lawrence Tiller, graduate of the College of Pharmacy of Baylor University and formerly of the Chemical Warfare service of the U.S. Army, has been appointed executive assistant to Dr. Theodore G. Klumpp, president of Winthrop Chemical Company.

Dr. Clarence Taylor Van Meter, assistant professor of chemistry and physics in the University of Pittsburgh College of Pharmacy, has been appointed scientific director of Reed and Carnrick, Jersey City, N.J. Dr. Van Meter holds the degrees of Ph.G., B.S., and Ph.D. from the University of Pittsburgh, and has been connected with the faculty of the institution since 1926.

Eugene Meyer, LL.D., editor and publisher of the *Washington Post,* has been elected president of the National Committee for Mental Hygiene.

Dr. Charles Franklin Kettering, vice-president of General Motors Corporation and general manager of its research laboratories, has been elected president of the American Association for the Advancement of Science.

Colonel Anthony J. Lanza, M.C., director of the occupational health division, preventive medicine service, Office of the Surgeon General, has retired from active duty to resume his work as assistant medical director of the Metropolitan Life Insurance Company.

Brigadier General James S. Simmons, U.S. Army, chief of the preventive medicine service, Surgeon General's Office, was named president-elect of the American Society of Tropical Medicine at its annual meeting held in St. Louis, Mo.

Colonel Paul Russell, M.C., former malariologist in the North African Theater, has been assigned to the Army Medical Center, Washington, D.C., as an instructor in tropical medicine. He recently returned from a year's service in Africa and Italy.

Colonel Harry A. Bishop, M.C., Washington, D.C., has been awarded the United States of America Typhus Commission Medal for "exceptionally meritorious conduct in the performance of outstanding service from December 1943 to February 1944, at Naples, Italy."

Lieutenant Colonel Leon H. Warren, M.C., Philadelphia, Pa., has been appointed a member of the National Research Council, representing the War Department in the Division of Medical Sciences. Colonel Warren is now assistant director, technical division, Office of the Surgeon General.

Dr. Mark F. Boyd, Tallahassee, Fla., was elected president of the American Academy of Tropical Medicine at the annual meeting held in St. Louis, November 15, 1944.

SIGISMUND S. GOLDWATER

SOLOMON R. KAGAN, M.D.
Boston, Mass.

Dr. Sigismund S. Goldwater was a recognized authority on administrative medicine and public health, and attained an international reputation in the field of hospital construction. He was the author of more than one hundred original articles in the field of public health and hospitals; these range from his clinical paper, "Notes on Blood Pressure in Man" (W. T. Lusk Memorial Science Prize Essay, 1901) through a long list of papers covering every phase of hospital work. In the last years of his life his energies were devoted to the defense of the voluntary system of hospitals and of group medical insurance plans for people of moderate means.

In 1903, at the age of twenty-nine, after a year's internship he was appointed superintendent of the Mount Sinai Hospital in New York. Up to that time few physicians had been interested in the problems of hospital management, and usually lay representatives of the board of trustees were in charge of these institutions; Dr. Goldwater became a pioneer in this neglected field of medicine. In February 1904, the Mount Sinai Hospital was moved to new quarters and in a short time became a model institution through improved organization of its services and inauguration of higher standards of nursing care and of medical and surgical service. Dr. Goldwater believed that it was better to have special departments in a general hospital rather than isolated special hospitals, and he succeeded in making the Mount Sinai Hospital a well rounded general hospital equipped to supply special care as needed. His administrative work, his addresses, and printed papers attracted wide attention, and soon he was appointed municipal expert in hospital administration and planning, acting as consultant in the planning of pavilions A and B for Bellevue Hospital in New York. In addition to his ability as an organizer, he revealed a gift for dealing with spaces and a talent for mediation; trustees, medical boards, and architects throughout the country sought his advice. He participated in the construction of hospitals in New Orleans, Philadelphia, Pittsburgh, San Francisco, St. Louis, Cleveland, Rochester, and many other communities. Through his manifold activities, his ideas exercised great influence and he became a leader in many fields related to medical care.

In 1914 Dr. Goldwater was appointed commissioner of health for New York City. He initiated new policies, enlarged and improved the functions of the department. He was the first to suggest dividing the city into health districts, setting up health district No. 1; he also established the first bureau of public health education in any health department in this country, issuing newspaper releases and bulletins.

In 1917 Dr. Goldwater was made director of the Mount Sinai Hospital; he held this position until 1929. In 1917 he was chairman of the hospital division of the Council of National Defense, and influenced greatly the methods of organization of army camp hospitals. He was consulting expert to the United States Public Health Service (1918-30) and in 1924 he was medical councilor to the United States Veterans' Bureau. During this period he was advisory expert to some two hundred hospitals in this country and throughout the world, including Canada, Tokio, Manila, and Russia. In 1927 he went to London to advise in the reorganization of the British voluntary hospital system.

In 1934 he was appointed commissioner of hospitals for New York City, which position he held until 1940. During his incumbency he improved the standards of service in the municipal hospitals by expanding nursing care, by selecting qualified executives, and by raising the standards of medical service. By his creative and energetic work he imbued the municipal hospital system with a spirit of devotion to the welfare of the patients. As the result of his leadership, additional institutions and new pavilions increased the bed capacity of the city hospitals by more than five thousand.

Dr. Goldwater saw the need of improved care for chronic patients and he secured from individuals and foundations a fund of $25,000 for three years, to supplement the appropriation of the board of estimate, for research work in the field of chronic diseases. He finally succeeded in securing an appropriation of seven million dollars for the construction and equipment of a hospital for the care and study of chronic ailments, with a capacity of 1500 beds. This institution was opened in 1940 under the name of Welfare Hospital; later its name was officially changed to Goldwater Memorial Hospital.

Dr. Goldwater contended that it is the free community hospital, not the government hospital system, that holds the record for quantity as well as quality of service, that local action based on the voluntary work of lay and medical groups renders better service to the patient than money grants and administrative direction by federal agencies. He held that the expansion and refinement of the hospital system in this country depends upon the development of local nonprofit prepayment hospital service plans. He believed that government service in the field of medicine should be established only in communities that fail to provide adequate medical service for the sick poor. In 1940 he became president of the Associated Hospital Service of New York and served in that capacity until his death.

Dr. Goldwater was active in many fields and was accorded many honors. He was a trustee of the Mt. Sinai Hospital, of the Huntington, L.I., Hospital, and of the United Hospital Fund; consultant to the Murray and Leonie Guggenheim Foundation and to the Pan-American Sanitary Bureau. In 1908 he was elected president of the American Hospital Association and in 1940 received its award of merit. He was vice-president of the New York Academy of Medicine (1913), of the National Institute of Social Sciences (1918-31) and president of the American Conference on Hospital Service (1924-26). He received the honorary degree of D.Sc. from Marquette University in 1905, and of D.P.H. from New York University in 1939. The Mt. Sinai Hospital has established a Goldwater Memorial Fellowship in hospital administration.

Dr. Goldwater was born in New York, February 7, 1873, and graduated from New York University and Bellevue Hospital Medical College in 1901. He died on October 22, 1942. Courage, integrity, and fairness

won him respect as an administrator. In organizing and planning hospitals he combined imagination with understanding of practical problems and scrupulous attention to detail. Modesty, reserve, humor, and charm were marked characteristics, while zeal, energy, and power made him a commanding personality.

176 Seaver Street

Book Reviews

Internal Medicine

Fundamentals of Internal Medicine. By Wallace Mason Yater, A.B., M.D., M.S., in (Med.), F.A.C.P., professor of medicine and director of the department of medicine, Georgetown University School of Medicine, etc. Second edition. New York and London: D. Appleton-Century Co., Inc., 1944. Pp. 1204. Price $10.00.

The fundamental character of the book has been retained in this new war edition. Nevertheless, subjects of interest to the internist and the armed forces are included, especially aviation medicine, immersion foot, blast injuries, chemical warfare, industrial diseases, pulmonary disorders, war nerves and tropical medicine. Other subjects include pneumonia, blood typing, hypoproteinemia, steatorrhea. New advances in therapeutics have been included wherever clinical experience confirmed effectiveness, i.e., dicumeral and penicillin. The author has also included valuable chapters on the physician himself, symptomatic treatment and clinical tables. This compact treatise on medicine relieves the over-burdened physician from reading detailed literature. It is replete with essential knowledge of how to treat the sick. The contributions from authors in the service have added considerably to its value on military medicine. The clear, succinct style in which this treatise is presented gives so much information in so little space that the book will be a welcome addition to the practitioner's daily armamentarium.

Operative Surgery

Operations of General Surgery. By Thomas G. Orr, M.D., professor of surgery, University of Kansas School of Medicine. With 1396 step-by-step illustrations on 570 figures. Philadelphia and London: W. B. Saunders Company, 1944. Pp. 723. Price $10.00.

After training many young surgeons, Orr is convinced that there is need for an operative surgery which contains "all the essentials of surgical technique." However, not only the student or beginner has been held in mind here, but also the general surgeon, who may be called on to do operations usually performed by "specialists," but which may demand immediate care by whomsoever is on the spot. The book is divided into *systems* rather than according to regional anatomy. Emphasis is placed on wound healing, one of the most absorbing chapters in the book. Concerning this the author rightfully says that these "initial steps" must be learned thoroughly if any surgery is to be successful. Moreover, the importance of vitamin deficiency is stressed in those patients where wound healing is slow, especially deficiency of vitamin C (ascorbic acid). Wounds which show poor tensile strength, gaping, rupturing and "livid" granulation tissue may so behave because of a poor quantity or quality of vitamin C. There is also the matter of sutures. There seems to be a growing feeling that nonabsorbable sutures are preferable to catgut of whatever kind. Silk and linen are to be recommended for most cases. There are several illustrations which show various methods of tying sutures, especially the drawings on page 20.

The author does not assume that anyone can "learn" surgery from a book, even when every "step" is fully illustrated and described; for there is no field where learning to do by actual doing is more imperative. The next best thing is to observe skilled surgeons at work, but even here there is no substitute for "putting one's hand into a wound". Most of us learn by seeing, nevertheless, and sight learning is the foundation of this book even more than reading and studying the text which is ample, concise, direct and forceful. Here is an up-to-date practical book which deserves wide recognition.

Philosophy of Scientific Investigation

Maurice Arthus's Philosophy of Scientific Investigation. Preface to *Del-Anaphylaxie à l'Immunité;* Paris, 1921. Translated from the French, with an introduction by Henry E. Sigerist. Foreword by Warfield T. Longcope. Baltimore: The Johns Hopkins Press, 1943. Pp. 26. Price $.75.

This little brochure is reprinted from the *Bulletin of the History of Medicine,* October 1943. It is one of those epitomized flashes of philosophy of the kind that Osler did in his *Aequanimitas,* Voltaire in his *Method of Zadig,* and Abbe Dimnet in *His Art of Thinking.* As an approach to scientific study and research, these mental exercises give zest and flavor to the daily round. They are an antidote to a stalemate.

Some twenty years ago, Arthus, a French physiologist who was a pupil of Claude Bernard and Pasteur, or, should we say, an imitator, wrote a dissertation concerning the relationship of anaphylaxis to immunity. This translation from the French by Dr. Sigerist is the introduction to Arthus's book, which is now said to be unobtainable. There is nothing very new or original in Arthus's observations. His approach was an effort to inspire in others what he himself had felt as a student and researcher. No doubt his style is commanding and has the Gallic quality so intriguing to lovers of language. If a scientist has not this quality of renewal of the spirit for the humdrum tasks of the laboratory, his work becomes prosaic, stodgy and unfruitful. The philosopher must always possess high spiritual, not of necessity religious, qualities. Some one may say that there are few philosophers in the laboratory, but many technicians. May be so, and may be also, that if the technicians would derive more inspiration from much writings as Arthus has set down, more philosophers might come out into the open, and the whole world would be benefitted thereby. Both Dr. Sigerist and Dr. Longcope have performed a service to scientific thought by reminding us of Arthus and his forbears.

Inhalation Therapy

Principles and Practices of Inhalation Therapy. By Alvan L. Barach, M.D., associate professor of clinical medicine, College of Physicians and Surgeons, Columbia University. With fifty-nine illustrations. Philadelphia, London and Montreal: J. B. Lippincott Company, 1944. Pp. 315. Price $4.00.

Inhalation therapy must be as old as medicine itself. For ages it has been a remedy for coughs and colds administered by grandmothers. The old-time practitioner prescribed compound tincture of benzoin for laryngitis; it is still useful. The modern conception of inhalations, however, has to do not only with infections of the airways but with atelectasis, pulmonary edema, emphy-

sema and cerebral thrombosis! Also for gas poisoning, severe hemorrhage and shock, and for flyers who suffer from altitude sickness. Oxygen-helium combinations, oxygen alone, carbon dioxide, and vaporized solutions of epinephrin and neosynephrin are used. All of these agents are well known but the successful application of them constitutes a new kind of therapy which has proved to be of great value. There is much to be learned about apparatus and technique. Few among us, for example, are familiar with the tracheal catheter which can be used to abstract excretions and secretions from the lower airways, and also for insufflation of gases in anesthesia, etc. One needs to understand positive and negative pressures, and must bcome familiar with respirators of varying kinds. In fact the proper administration of inhalation therapy depends quite as much upon the kind of apparatus used as upon the nature of the inhaled agent.

Periodical medical literature is rich in facts about this form of therapy, but it is widely scattered. In this book Dr. Barach seems to have brought between its covers all that has been written out of rich individual experience. After reading it, many a physician will wish that he might "take a course" in inhalation therapy, but he can acquire much from an assiduous reading of this text.

Arthritis

Your Arthritis: What You Can Do About It. By ALFRED E. PHELPS, M.D. With an introduction by R. GARFIELD SNYDER, M.D. Illustrations by JAMES MACDONALD. New York: William Morrow and Company, 1943. Pp. 192. Price $2.00.

Dr. Phelps is a great believer in cooperation of patient and physician. The patient, he says, ought to have "fundamental knowledge of the nature of his disease and its problems". Just because the entity we call "rheumatism" is none too well understood in detail by the rank and file of physicians, the patient has, hitherto, been left somewhat in the dark. One wants to know whether climate or heredity or environment or injury or infection causes it, and, if so, whether there is a "cure". Chapter 11 attempts to answer this question but it cannot do so extensively in the space allotted. First, the diagnosis of "type" must be definite and certain, whether it is "specific", "nonspecific" or under what heading it may be classified. Then comes the matter of administering gold salts, chemotherapy, fever therapy, vaccines, the "rays", ultraviolet, infrared, etc., and vitamins. High doses of vitamin D, known as ertron, have been given successfully in some cases, and the author seems rather enthusiastic about it. The daily dose is from one hundred fifty thousand to five hundred thousand units and the blood is watched for too much calcium or phosphorus. The method, however, is not here sufficiently detailed.

Regarding that *bête noire,* "the small of the back", which is responsible for so much "misery", the author emphasizes curvatures and maladjustments especially in the lumbar region as causes of "radiculitis". Anyone who has ever has an attack of lumbago will admit the severity of the pain which is often totally disabling. Change from the prone to upright posture is said to have something to do with the tendency to lower back pain.

"Diet Has Its Uses" is the title of the final chapter. Admittedly, this subject, no matter how dealt with, often results in confusion worse confounded. It is doubtful, whether clarity in the matter of diet is obtained in this book, but the author's protocols will stir up thought and, perhaps, indignation in some minds which hold on to "the old ideas". *Your Arthritis* is readable, but a trifle too sketchy to be of great value to the physician. Patients will enjoy it, however.

Trauma

Technique in Trauma. Planned Timing in the Treatment of Wounds including Burns. From The Montreal General Hospital and McGill University. By FRASER B. GURD, M.D., C.M., and F. DOUGLAS ASKERMAN, M.D., C.M. In collaboration with JOHN W. GERRIE, M.D., C.M.; JOSEPH E. PRITCHARD, M.D., EDWARD S. MILLS, M.D., C.M., and FREDERICK SMITH, M.D. Preface by JOHN S. LOCKWOOD, M.D., University of Pennsylvania; Commentary by RALPH R. FITZGERALD, M.D., C.M., McGill University. Philadelphia, London and Montreal: J. B. Lippincott Company, 1944. Pp. 68. Price $2.00.

This is another "burn book" by what may be called the Montreal school. The term "school" has to do with the more or less crystallized thinking on a given subject in a given locality. It is significant that the Lippincott Company brought out in 1943 a book on *Skin Grafting of Burns,* by Brown and McDowell of Washington University, St. Louis. Lockwood, in his preface to this Montreal volume speaks of the increasing interest in burns both in civilian and military life, and of a reexamination of the whole problem of burn management. He also says that the use of coagulants on burned skin is falling into disrepute because they add further injury to the subcutaneous tissue, because the resulting eschar blocks drainage and renders infection more serious, and because of more likely absorption of burned and toxic tissue substances into the general system. This is especially true of tannic acid covering which is being widely discarded of late. The use of the sulfa drugs internally also may add to the burden carried by vital organs, liver, kidneys, et al., but surface dusting and sulfa drugs is still useful in holding infection in check. There is not much danger of poisoning by absorption of these dyes from the burned area. The basic principles of soap and water cleansing, early grafting before excessive granulations form, and occlusive dressings are here emphasized as they have been by others. At the end of the book the "commentary" by Fitzgerald is especially helpful because of the question and answer method he applies to the whole subject of burns. It is a form of reasoning by analysis which might well be used in solving other medical problems.

Handbook of Medicine

Minor Medicine. Edited by SIR HUMPHRY ROLLESTON, Bt., G.C.V.O., K.C.B., M.D., F.R.C.P., and ALAN A. MONCRIEFF, M.D., F.R.C.P. The Practitioner Handbooks. London: Eyre and Spottiswoode, Ltd., 1942. Pp. 223. Price 16s. net.

This new book is produced in complete conformity with the authorized economy standards. So states the foreword on the title page. We are to be very thankful for so many small favors. There are twenty-four chapters, each considering some one common minor complaint. Chronic constipation, by Sir Adolphe Abrahams, is the first; the common cold, by J. Browning Alexander, is the eighth; infantile convulsions, migraine, corns, warts and boils are fifteenth, sixteenth and twenty-third. Each occupies about eight pages of text. The sulfonamides are found a score of times throughout the text. Listed as one of *The Practitioner Handbooks,* this sample is not over helpful for physicians on this side of the ocean.

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JANUARY 1945

Medicolegal Notes

Children's Hospital Dormitory Held Sufficiently Guarded

The Second Circuit Court of Appeals, Martucciv, Brooklyn Children's Aid Society, 140 F. 2d 732, reversed judgment in the Federal District Court for Eastern New York for plaintiffs for personal injuries sustained by the infant plaintiff while an inmate of defendant's House for Crippled Children, and remanded the cause. The child fell against a pane of glass in an unguarded window in the house in which he lived. This was the second appeal in the case. The first resulted in reversal of a directed verdict for the defendant (133 F. 2d 252). The question was whether the defendant was guilty of actionable negligence in failing to provide safe and suitable quarters for the care of the child who could walk only with the aid of a brace on his right leg. The dormitory was lighted by French windows coming down close to the level of the floor. Another boy was trying to take from the child a paper on which was a picture. His head came against the sash so violently that the glass was broken, his face was cut, and one eye destroyed.

The windows had for years been protected by wooden bars, but these had been removed because they interfered with the cleaning of the windows and had not been replaced. Evidence was held admissible that the bars were originally placed across the windows to protect the glass from objects thrown by the children and not to protect the children. Evidence that the windows had previously been left thus unguarded without harm to the children was held admissible to show that failure to replace the bars was not negligence. The two nurses usually present were temporarily out of the room at the time of the accident. This did not necessarily establish negligence on the part of the hospital. Being a charitable institution the hospital was liable only for failure to exercise due care.

Quantum of Proof Required in Malpractice Cases

In a malpractice action against an eye specialist for damages for the loss of vision of the plaintiff's left eye, the Arkansas Supreme Court held, in a four to three decision, that evidence that the specialist did not sterilize his instruments and wash his hands before performing an operation for pterygium and that the eye thereafter became infected, was a sufficient basis for a finding by the jury that the defendant's negligence was the proximate cause of the injury.

The majority opinion was based upon the theory that in a case of this kind a plaintiff is not required to show to a mathematical certainty or to the exclusion of every other hypothesis that his injury occurred as a result of the negligence of which he complains. And where it was undisputed that the defendant was negligent in the matters alleged and that a serious and unusual infection followed the operation, and it appeared that all the causes for this infection suggested by the defendant and his expert witnesses were excluded by testimony which the jury had a right to believe, the jury was held authorized to find that the infection was caused by the defendant's negligence. No dissenting opinion was filed. Lanier vs. Trammel, 180 S.W. 2d 818.

Disability from Exposure to Coke Dust, Gas Fumes and Heat

Where, in a workmen's compensation proceeding in Oklahoma, the disability claimed requires skilled professional men to determine its cause and extent, the question is one of science and must necessarily be proved by the testimony of skilled, professional persons. Johnson vs. Ben Franklin Refining Co., Oklahoma Supreme Court, 151 P. 2d 428. Compensation was allowed for disability to heart and lungs alleged to have been caused by exposure to coke dust, gas fumes and extreme heat while engaged in cleaning a coke oven on a specified day.

Expert Medical Witnesses Need Not be Specialists

Qualified medical doctors are competent to testify on all medical subjects upon which they claim sufficient ability to express an opinion. They do not have to hold themselves out as specialists in the particular branch they are to testify about, such as x ray. If they do not possess sufficient knowledge, that deficiency may be disclosed on cross-examination. The qualification of an expert is for the determination of the trial court, and that determination will not be disturbed where the ruling is supported by evidence. Young vs. Stevens, New Jersey Court of Errors and Appeals, 39 A. 2d 115.

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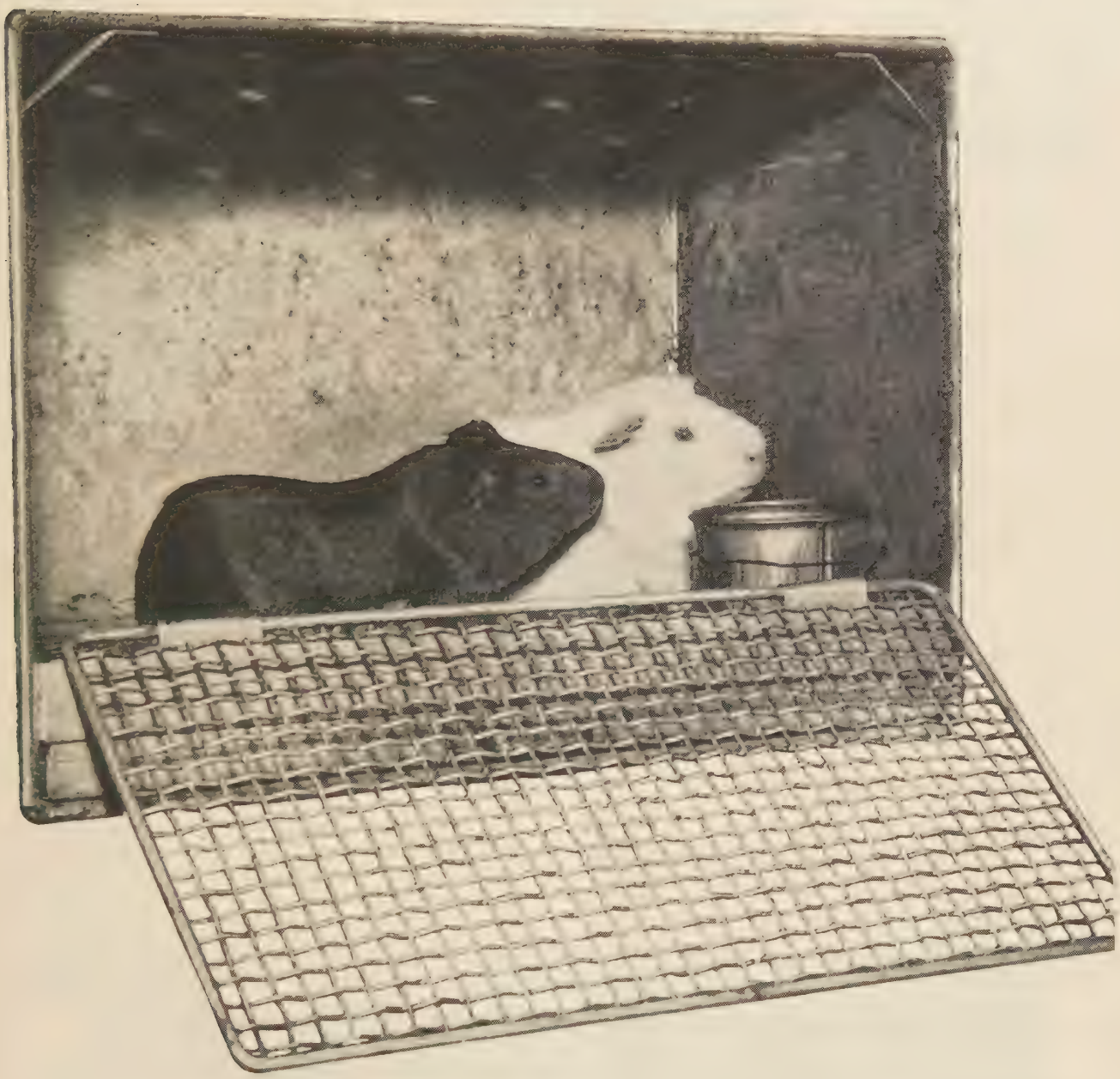

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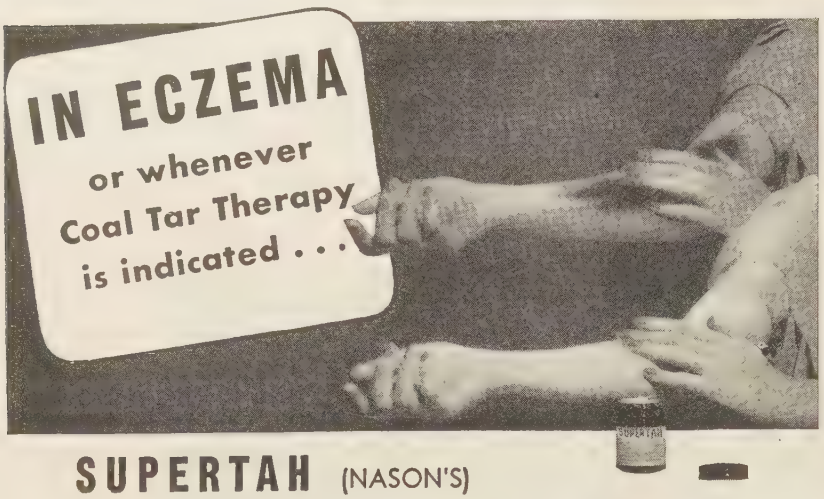

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Additional Grants for the Advancement of Physical Medicine

The administrative board of the Baruch Committee on Physical Medicine recently announced the granting of an additional sum of $185,000, given by Mr. Bernard M. Baruch for the further advancement of the program in physical medicine and the physical rehabilitation of those disabled in the war. This sum has been divided into seven grants as follows: $50,000 to the Massachusetts Institute of Technology in support of a five-year program of training and research in electronics, instrumentation and physics in relation to medicine; $40,000 to the Medical School of the University of Minnesota to support the development of a three-year teaching and fellowship program in physical medicine; $30,000 to the Medical School of Harvard University for the establishment of a three-year program to provide fellowship or residencies to be used for the benefit of qualified physicians who are selected to be trained in this field; $30,000 to the Medical School of the University of Southern California to inaugurate a program of teaching and research in physical medicine in its medical school; $15,000 to the Medical School of the University of Iowa to assist in a joint research and teaching program concerning the effectiveness of different methods of applying heat to the deep tissues of the human body; $15,000 to the Medical School of the University of Illinois to inaugurate a teaching program in physical medicine at its medical school; and $5,000 to Marquette University Medical School for continuance of research in the physiology and pathology of nerves and muscles as related to physical medicine.

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chological and psychiatric aspects of physical medicine will be available at Harvard. The first year will be devoted wholly or in part to basic research related to physical medicine; the second year will be spent in clinical training in physical medicine at the Massachusetts General Hospital and other hospitals affiliated with the Harvard Medical School, and in the third year fellows will be assistants in physical medicine with clinical responsibilities.

Eponyms

Hansen's disease.—The study of leprosy received a great impetus with Hansen's discovery of the causal relation of the bacillus of leprosy to the disease. Gerhard Armauer Hansen was born in Norway in 1841. He made his mark in microscopic anatomy, studied leprosy under Daniellsen and Boeck, established a system of isolation of lepers, and revolutionized the conception of the disease. Hansen was president of the International Leprosy Congress in 1910. He died suddenly in 1912.

Weir Mitchell's disease.—The first American eponym in dermatology was erythromelalgia, or Weir Mitchell's disease. Silas Weir Mitchell was born in Philadelphia in 1829. He was the son of a prominent physician, and professor of medicine at Jefferson Medical College. Weir Mitchell's life has been an inspiration to many, and in addition to his high attainments in the art of medicine was well known for his skill as a novelist, biographer and poet. The disease which bears his name was described in 1872. It is said that Paget made an early note on this disease and that Graves gave an independent description. The disease has also become known as Gerhardt's disease.

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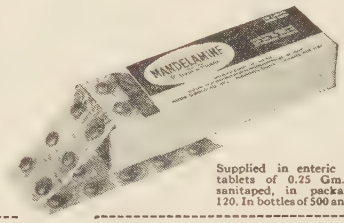

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Army Treatment of Gonorrhea and Syphilis

Brigadier General Hugh J. Morgan, United States Army, chief consultant in medicine to the Surgeon General, in an address delivered at the annual meeting of the Association of Military Surgeons of the United States, said that in September 1944 the penicillin supply problem had eased to the point where the Army made penicillin the drug of choice in the treatment of gonorrhea and limited the use of the sulfonamides to cases which did not respond to adequate penicillin therapy or where penicillin was not available through normal supply channels. In outlining the treatment, General Morgan said that the initial treatment schedule recommended was twenty thousand units intramuscularly every three hours for a total dosage of one hundred thousand units. Patients in whom a favorable response was not obtained by the third day were re-treated with one hundred thousand units. When patients failed to respond to the second course, a third course of penicillin, totaling not less than three hundred thousand units, administered in twenty thousand unit doses every three hours, was recommended. Should this fail, sulfathiazole or sulfadiazine was used, employing a dosage of four grams initially, followed by one gram every four hours day and night for five days.

While it was too early to evaluate the effect of this new policy regarding the treatment of gonorrhea, General Morgan said there was every reason to believe it would be looked upon in retrospect as constituting one of the most conspicuous advances made during this war in military medicine, in the light of its almost certain favorable effect upon morbidity and noneffectiveness, and this in spite of a rising incidence rate.

In October 1944, the penicillin treatment of syphilis was authorized throughout the Army. The total dosage for early syphilis and latent syphilis, said General Morgan, was two thousand four hundred units given in sixty consecutive intramuscular injections of forty thousand units at three hour intervals day and night for seven and one-half days. No additional antisyphilitic therapy was to be given during or after the completion of the course of penicillin, except in the case of penicillin treatment failures. Within the limits imposed by this short period of study, General Morgan said there was reason to believe that this method of treating syphilis would be every bit as effective and much less dangerous than any treatment plan heretofore employed.

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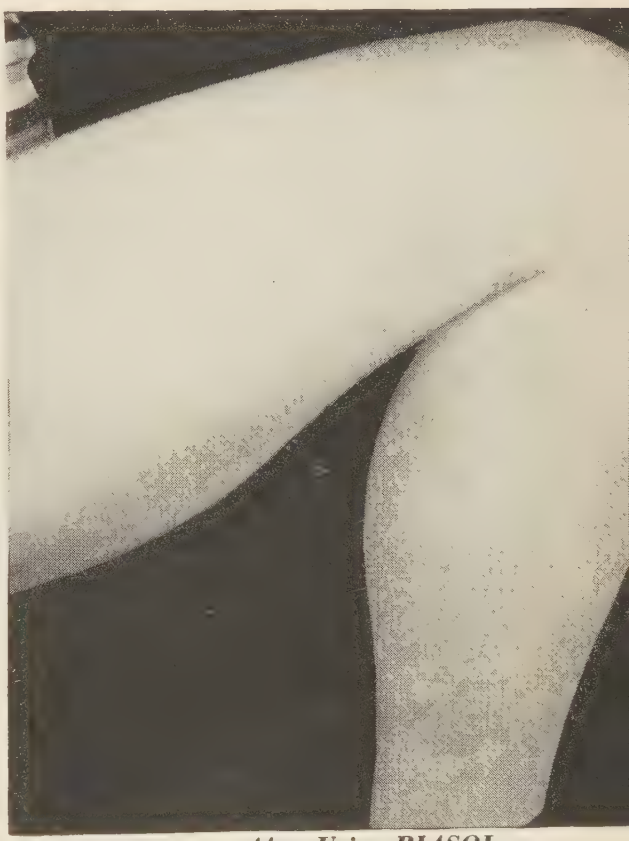

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Weakness and Fatigue

Frank N. Allan (*New England Jour. Medicine,* Sept. 21, 1944) compiled data on three hundred consecutive cases at the Lahey Clinic in Boston, in which weakness, fatigue or weak spells were the chief complaint. In sixty-one cases it was found that the cause was a physical disorder, and in two hundred and ninety-three it was not caused by any physical disturbance, but was the result of a nervous state. Weakness due to hunger and fatigue caused by hard labor were not encountered. These conditions, however, are not likely to bring the patient for medical attention.

The nervous disorders in thirty-nine of the three hundred cases were classified as psychoneurosis in forty-four cases, mental depression in six, and benign nervous states in one hundred and eighty-nine. In twenty-eight of the cases in which a physical disorder was found to be the cause of weakness, it was possible to make a positive diagnosis by clinical observation alone. In the others, laboratory tests or roentgenograms were essential to reveal a hidden disease or confirm the diagnosis. The most frequent physical disorders were chronic infection, diabetes, heart disease, various neurological disorders and serious diseases of the blood. Certain conditions, such as vitamin deficiency and glandular disorders, considered widespread causes of weakness by both the laity and the medical profession, were actually found to be rare, and not a single case of weakness due to liver trouble, poor elimination or low blood pressure was encountered.

The author concludes that although a high percentage of patients with these complaints have no physical disorder, there is a group in which physical conditions of unusual interest may be discovered.

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*Musser, John H., Internal Medicine, Lea and Febiger, Philadelphia, 3rd Edition, 1938, page 1048.

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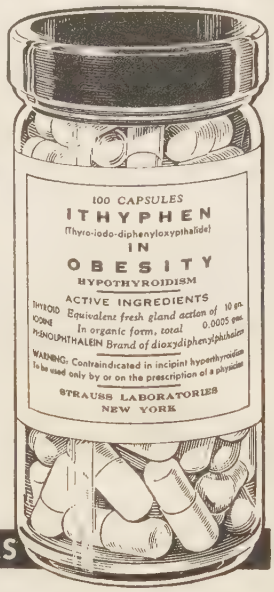

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Strength of the Army Medical Department

In connection with the recent announcement that the Army is no longer recruiting physicians, the following figures issued by the Surgeon General's Office, are of interest:

The Army Medical Department has grown from 8,010 at the beginning of World War I until it now numbers 680,891. Of this number approximately 44,651 are in the medical corps, 14,948 in the dental corps, 2,012 in the veterinary corps, 2,364 in the sanitary corps, 15,078 in the medical administrative corps, 59 in the pharmacy corps, 40,305 in the army nurse corps, and there are 559,327 enlisted men, 813 physical therapy aides, and 1,334 hospital dietitians.

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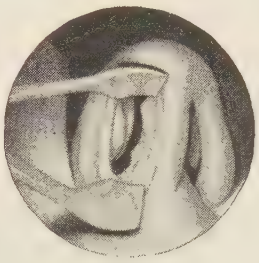

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Arch. Otolaryng., 39:109-123, 1944.

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In addition to the medical journals, unpublished manuscripts describing even more recent developments are also microfilmed, and upon request sent to our military medical personnel.

Typhus and Malaria in Puerto Rico and the Virgin Islands

The incidence of typhus fever has been increasing for the last year in District No. Six which comprises Puerto Rico and the Virgin Islands, and an officer has been assigned to the office to plan a typhus control unit in the Insular Department of Health, Rat surveys will be made, and a campaign has been started to improve garbage disposal. According to the *Military Surgeon*, December 1944.

A reduction of eighty percent in the military malaria attack rate has been reported in Puerto Rico from June 30, 1943 through May 1944. It has resulted from the activities of Malaria Control in war areas, together with United States Army intrareservation control, and natural control resulting from drought.

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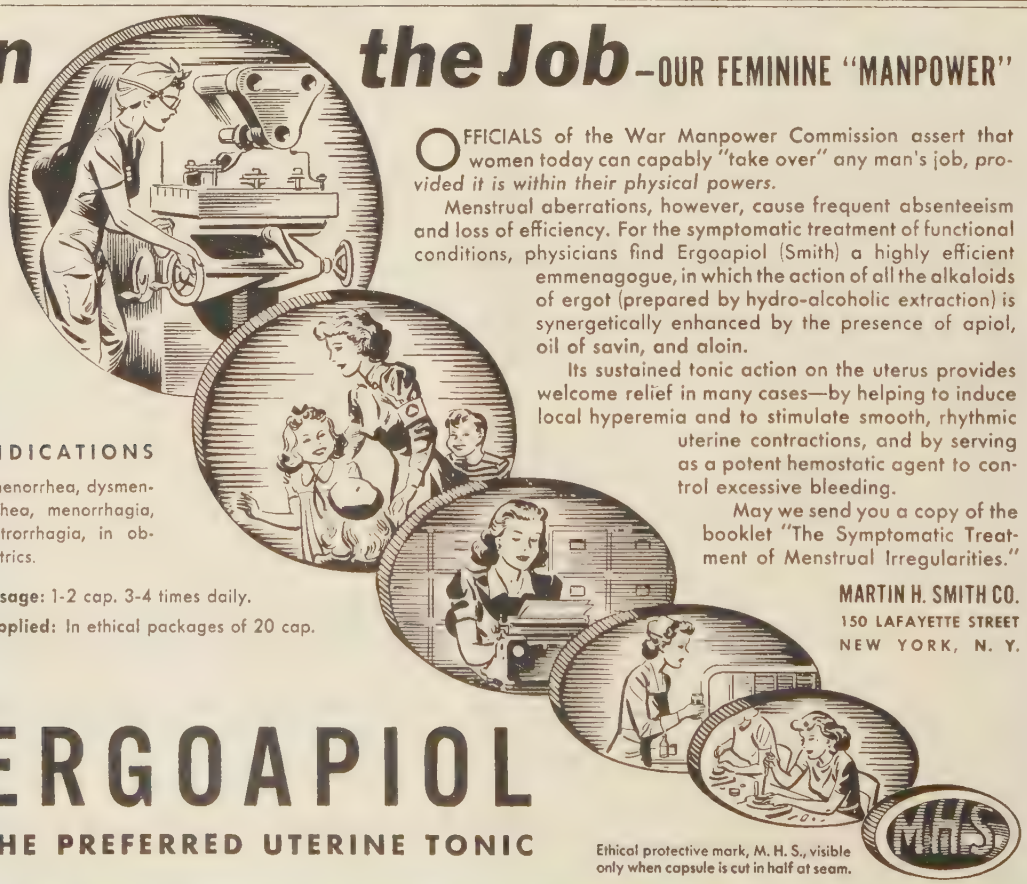

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The Burnham Soluble Iodine Company, in addition to its old reliable, Burnham Soluble Iodine, which has been highly regarded for over forty years, has recently placed on the market two new preparations which appear to be very interesting. Glyco-HCI and Glyco-HI are stable capsule forms of hydrochloric acid and hydriodic acid medication. They are both resonating addition compounds of glycocoll, the simplest amino acid, which dissociate in gastric juice liberating hydrochloric acid and hydriodic acid respectively.

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Master Metal Products Appoints Western Sales Manager

Master Metal Products, Inc., of Buffalo, N.Y., manufacturers of Medical Waste Receivers, announces the resignation of Mr. A. C. Mayer as sales representative in Washington and Oregon. Mr. W. C. (Bill) Newton has been appointed Western District Sales Manager effective January 1, 1945 and will personally supervise the sale of all Master Metal products in California, Washington and Oregon. Mr. Newton's headquarters are at 656 South Los Angeles St., Los Angeles 4, California.

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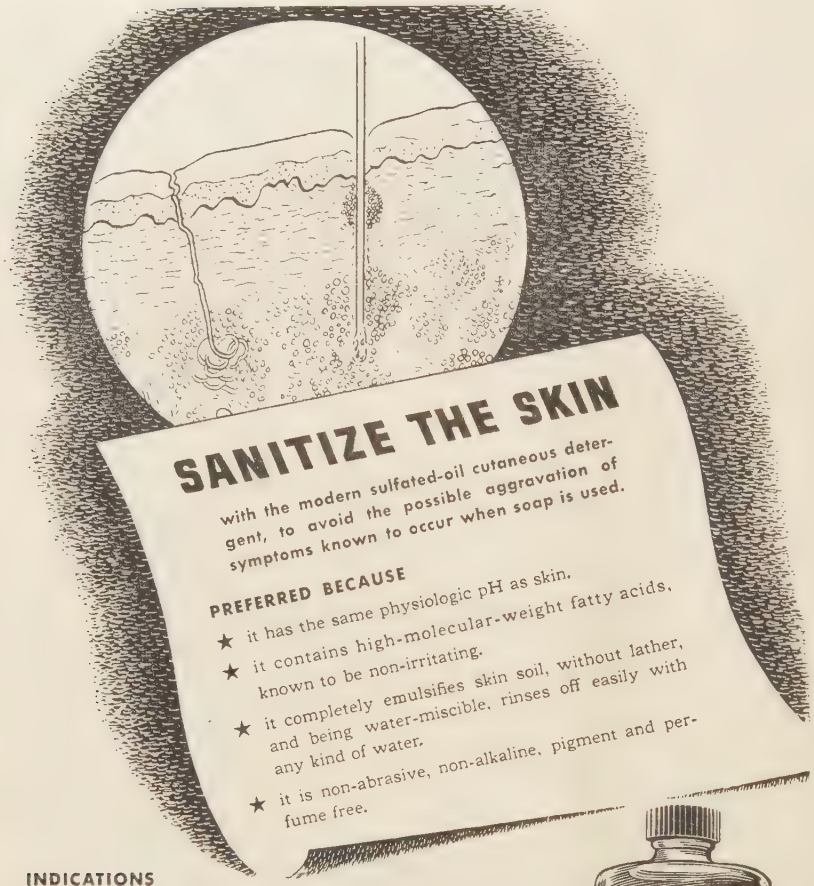
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Award of William H. Nichols Medal

Professor Vincent du Vigneaud, head of the department of biochemistry, Cornell University Medical College, has been awarded the William H. Nichols Medal of the New York Section of the American Chemical Society, one of the highest distinctions in chemical science. Professor du Vigneaud was cited for his researches on biotin, called nature's most powerful vitamin. His discovery of the chemical architecture of biotin was announced at a meeting of the Section on October 9, 1942. In 1943 the synthesis of biotin was achieved in the laboratories of Merck and Company, Rahway, N.J. The award also recognizes Professor du Vigneaud's researches on transmethylation, the mechanism of the conversion of methionine to cystine, and the use of isotopes in certain problems in intermediary metabolism. Professor du Vigneaud, the citation adds, has carried out important researches on the chemistry of insulin, on the posterior pituitary hormones, on glutathione, and on carnosine.

The Schering Award

The winners of the Schering Award Competition have been announced as follows: First prize of $500 was awarded to Maurice Silver, Class of 1945, Loyola University School of Medicine, Chicago, Ill.; the second prize, $300, to Sidney Kafka, Class of February, 1945, Middlesex University School of Medicine, Waltham, Mass.; the third prize was a dual award, $200 each, being given to Roslyn Wiener, Class of 1945, University of Michigan Medical School, Ann Arbor, Mich.; and Norman Hirt, Class of 1945, Queen's University, Kingston, Ontario, Canada.

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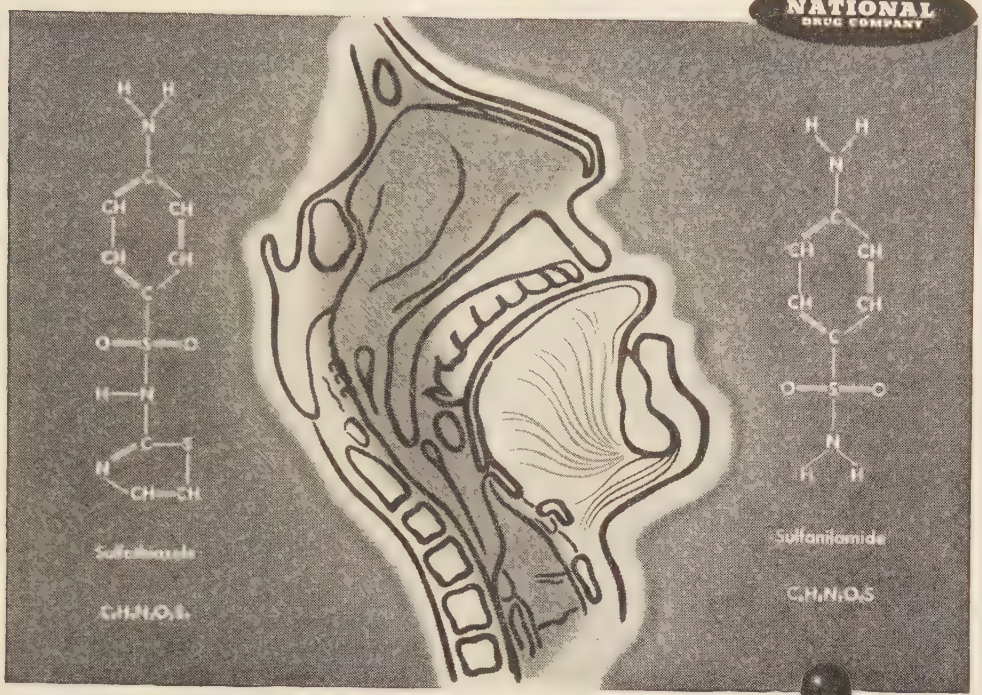

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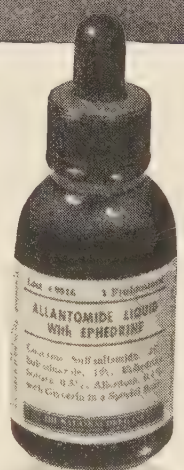

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Venereal Disease in the Caribbeans

Wide expansion of activities of the Anglo-American Venereal Disease Control Program in the Caribbean is expected upon completion of a Diagnostic Centre and Rapid Treatment Hospital in Port-of-Spain, Trinidad, B.W.I., according to the *Military Surgeon,* December, 1944. This program, sponsored by the Anglo-American Caribbean Commission, is a pioneer effort by the U.S. Public Health Service to aid a local health authority outside the United States in setting up modern venereal disease control. Trinidad was selected because of its extensive military and naval installations, and the high infection rate among soldiers and sailors stationed there. The task of the Public Health Service is to get the project started and to train local personnel to carry it on.

The Diagnostic Centre and Hospital will consist of two remodeled buildings, which are being transferred from the U.S. Army to the British Colonial Government. It will be equipped with 150 tons of supplies from the United States, some from the Colonial Government, and reconditioned material from the U.S. Army Salvage Pool on the island. Two venereal disease clinics are now in operation, and a modern hospital laboratory has been set up. Free serological service, darkfield, x ray, spinal puncture, and consultative services are offered to Trinidad's private physicians.

An extensive educational campaign has been started. Almost five thousand blood tests have been taken among the native population, of which thirty-five percent were positive. Numerous tuberculous infections were revealed in chest x rays of these same people. They were referred to the authorities for treatment.

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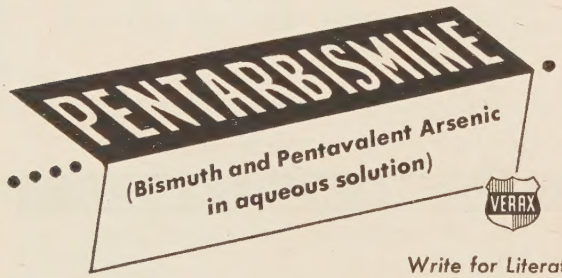
Appendicitis and Pregnancy

Bristow Johnson (*Med. Jour. Australia*, Oct. 7, 1944) in a review of appendicitis in its relation to pregnancy, says that the incidence of appendicitis in women is not influenced by the occurrence or presence of pregnancy. Primary acute appendicitis, he says, occurs at the same rate in all women irrespective of whether a pregnancy exists or not, but that pregnancy will aggravate an already existing case of chronic appendicitis. While no statistics are available to show how frequently appendicitis complicates pregnancy, it is known definitely that two percent of women with acute appendicitis are also pregnant. Eighty percent of these cases occur in the first six months and appendicitis is more common in the puerperium than is commonly supposed. The course of the disease is rapid and perforation may occur within a few hours, especially in the later months. While diagnosis is not particularly difficult up to the end of the twelfth week, it becomes increasingly difficult after the sixth month. Conditions requiring differentiation are right ectopic gestation, threatened miscarriage, acute salpingo-oophoritis, and twisting of pedicle of right-sided pelvic tumor.

In the treatment of acute appendicitis in the early months of pregnancy, operation should be performed when the patient's general condition is grave. With an early operation, the maternal prognosis is good, but if perforation has occurred a mortality rate of fifty percent must be expected in late pregnancy. There is little danger of abortion in simple cases, but after perforation, in fifty percent of the cases the uterus will empty itself spontaneously, thus increasing the mortality. In the last two months perforation is extremely dangerous to both mother and child, and Cæsarean section followed by appendicectomy is advocated as the procedure most likely to produce satisfactory results. Whenever possible a diseased appendix should be removed if there is a possibility of pregnancy occurring.

The author concludes that the extent to which modern chemotherapy will obviate the necessity for operative obstetric procedures awaits trial in a sufficient number of cases of the severe type.



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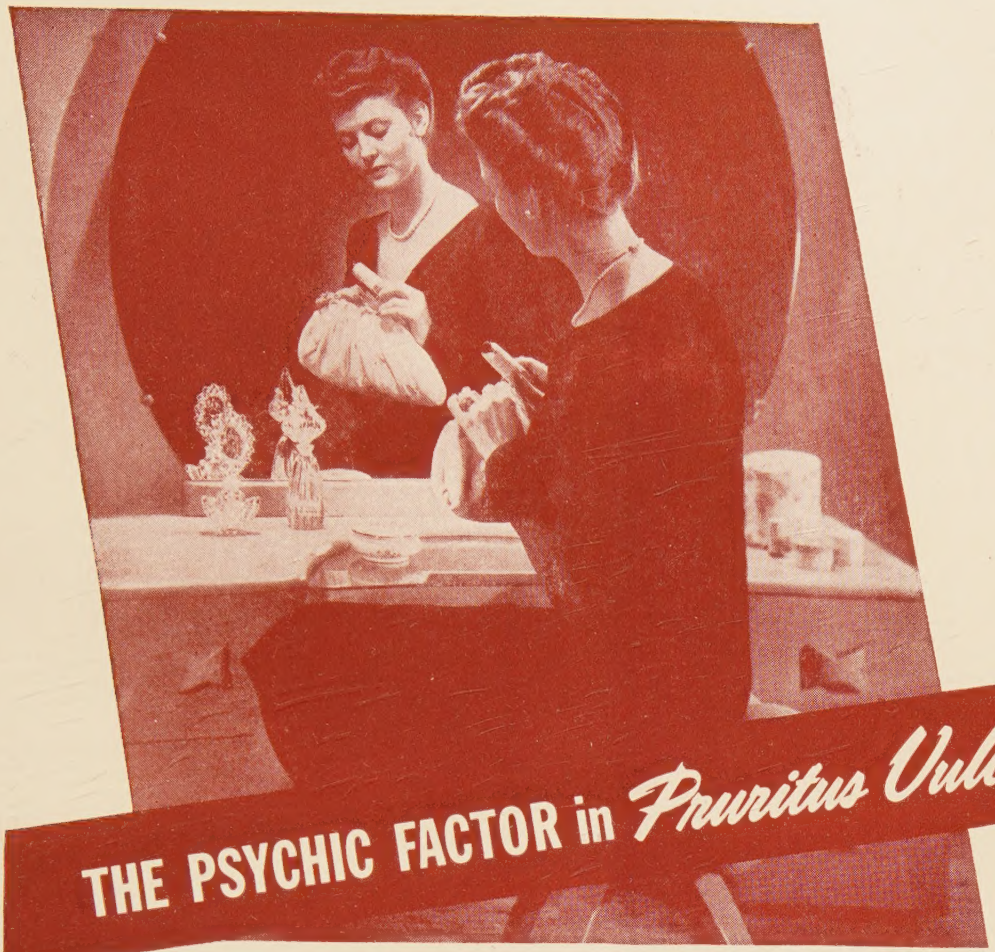

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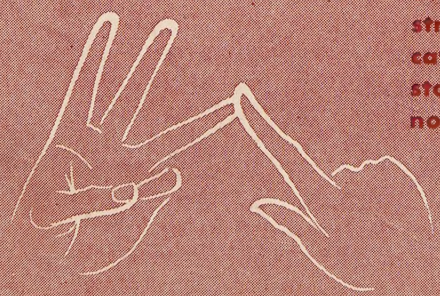

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